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

Attorney General[61]
Replace Chapter 9

Insurance Division[191]
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Replace Chapters 31 to 33 with Reserved Chapter 31 and Chapters 32 and 33
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Workers’ Compensation Division[876]
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Replace Chapters 2 to 5
Replace Chapters 10 and 11
CHAPTER 9
VICTIM ASSISTANCE PROGRAM
[Prior to 9/20/89, see Public Safety[661] Ch 17]

DIVISION I
ADMINISTRATION

   “Board” means crime victim assistance board.
   “Department” means Iowa department of justice.
   “Director” means director of the crime victim assistance division established in the department of justice.

61—9.2(912) Board.
   9.2(1) A crime victim assistance board is established pursuant to Iowa Code section 912.2A.
   9.2(2) Members of the board shall serve terms for three years and are eligible for reappointment to the board by the attorney general.
   9.2(3) The initial term of the board members shall commence on July 1 of the state fiscal year.

61—9.3(912) Expenses.
   9.3(1) Board members shall be reimbursed from the victim’s compensation fund for expenses actually and necessarily incurred in the discharge of their duties including attendance at board meetings, board committee meetings, and other activities on behalf of the board as designated by the board chair and approved by the department. Reimbursement for expenses shall conform with guidelines established by the department of revenue.
   9.3(2) A member of the board may receive, in addition to actual expense reimbursement, a per diem which conforms with guidelines established by the department of revenue.
   9.3(3) Expenses of the board and individual members shall be submitted to the director.

61—9.4(912) Chair of the board.
   9.4(1) The attorney general shall select one of the members of the board to serve as chair of the board. The chair shall serve at the pleasure of the attorney general.
   9.4(2) A member who is chair of the board and relinquishes or is removed as the chair may maintain board membership for the remainder of the term for which the member was originally appointed.

61—9.5(912) Resignations.
   9.5(1) Resignations from the board shall be made to the attorney general.
   9.5(2) Whenever a member of the board ceases to have the statutory qualifications for appointment to the board, that member shall be considered to have resigned and a vacancy shall occur on the board.
   9.5(3) A board member shall be deemed to have submitted a resignation from the board if any of the following events occur:
       a. The member does not attend three or more consecutive regular meetings of the board. This paragraph does not apply unless the first and last of the consecutive meetings counted for this purpose are at least 30 days apart.
       b. The person attends less than one-half of the regular meetings of the board within any period of 12 calendar months beginning July 1. This paragraph applies only to such a period beginning on or after the date when the person is appointed to the board.
       c. If the member receives no notice and had no knowledge of a regular meeting and gives the attorney general a sworn statement to that effect within ten days after the person learns of the meeting, such meeting shall not be counted for the purposes of this rule.
       d. The attorney general at the attorney general’s discretion may accept or reject such resignation. If the attorney general accepts it, the attorney general shall notify the member, in writing, that the
resignation is accepted pursuant to this rule. The attorney general shall then make another appointment to fill the vacancy.

61—9.6(912) Vacancies. Barring unusual circumstances, vacancies on the board shall be filled within 45 days after the attorney general is advised of the vacancy. Vacancies shall be filled for the remainder of the vacant term.

61—9.7(912) Meetings. The board shall meet a minimum of once per quarter. The board may also meet at the call of the chair or upon the written request to the chair of at least five members of the board.

61—9.8(912) Duties of board. The board shall adopt rules pursuant to Iowa Code chapter 17A relating to the administration of the crime victim assistance division including the adoption of administrative rules relating to the following:


3. Administration of the domestic abuse and rape crisis funds and the Iowa domestic abuse hotline funds provided in Iowa Code chapter 236.

4. Administration of other grants or funds available by public law for victim assistance and administered by the department.

5. Administration of the victim compensation program provided in Iowa Code chapter 912.

6. Administration of sexual abuse examination payments as provided in Iowa Code section 709.10.

7. Appeal procedures for victim compensation claims denied by the department.

8. Appeal procedures for grants administered by the department and denied by the board.

61—9.9(912) Director and staff. The attorney general shall employ a director and staff for the victim assistance division and they shall be employees of the department.

61—9.10(912) Duties of department. In addition to the duties contained in Iowa Code section 13.13, the department shall:

1. Administer other funds, grants, or programs for victim assistance created by public law or the department.

2. Provide administrative support to the board.

3. Enter into agreements under Iowa Code chapter 28E or other law including agreements with other state agencies and political subdivisions for the transfer to the department of funds authorized by law for victim service programs.

4. Accept, use, and dispose of contributions of money, services, and property, which are made available by an agency or department of the state or any of its political subdivisions, the federal government, a private agency, or an individual, that are specifically designated for crime victim assistance programs.

61—9.11 to 9.24 Reserved.

DIVISION II
CRIME VICTIM COMPENSATION

61—9.25(915) Administration of the crime victim compensation program. The crime victim assistance division of the department of justice shall administer the crime victim compensation program as provided in Iowa Code chapter 915. All questions, comments, requests for information, or
applications for compensation shall be directed to the crime victim assistance division. Requests should be addressed to: Crime Victim Assistance Division, Lucas State Office Building, Ground Floor, 321 East 12th Street, Des Moines, Iowa 50319; telephone (515)281-5044 or 1-800-373-5044.

61—9.26(915) Definitions. For rules of the crime victim compensation program of the crime victim assistance division of the department of justice, the following definitions apply:

“Affinity” means the relationship of persons who are related by marriage, cohabitation, or engagement to be married.

“Applicant” includes the following individuals who file an application with the crime victim compensation program:

1. A victim of a crime as defined in Iowa Code section 915.80.
2. A person responsible for the care and maintenance of a victim.
3. A resident of Iowa who is the victim of an act that would be compensable had it occurred within the state of Iowa and any of the following apply:
   - The act occurred in a state or foreign country that does not have a victim compensation program as defined in the federal law;
   - The act occurred in a state or foreign country whose victim compensation program has insufficient or inadequate benefits; or
   - The act occurred on an aircraft while in flight or occurred on waters outside of the jurisdiction of any particular state or country.
4. In the event of a victim’s death, the spouse, former spouse, child, foster child, parent, legal guardian, foster parent, stepparent, sibling, or foster sibling of a victim, or a person cohabiting with, or otherwise related by blood or affinity to the victim. An estate is not an eligible applicant for crime victim compensation. An estate shall, however, be reimbursed for funeral and burial expenses if the estate paid the costs on behalf of an eligible applicant who shall benefit from the proceeds of the estate.
5. A legal representative authorized to act on behalf of any of the persons listed above.

“Board” means the crime victim assistance board of the department of justice.

“A causal relationship” means that the crime would not have occurred without the action of the victim. A causal relationship exists if the actions of the victim result in a foreseeable injury, play a substantial role in the injury, or directly cause the injury.

“Claimant” means an applicant who has been found to be eligible for compensation.

“Cohabiting” means living in the same household. It is not necessary to establish that a sexual relationship exists between the parties.

“Compensation” means moneys awarded by the division as authorized in Iowa Code chapter 915.

“Consent” means to agree to a course of action or to voluntarily allow what is planned or done by another.

“Counseling” means problem solving and support concerning emotional issues that result from a compensable crime. Counseling is a confidential service provided on an individual basis or in a group. Counseling has as a primary purpose to enhance, protect and restore a person’s sense of well-being and social functioning. Counseling does not include victim advocacy services; conversation in a nonprivate setting such as the common area of a shelter or a courthouse; transportation; or attendance at medical procedures, law enforcement interviews or civil and criminal justice proceedings.

“Crime” as defined in Iowa Code section 915.80 includes:

1. Conduct punishable as a misdemeanor or a felony.
2. Property crimes including but not limited to robbery, residential burglary, and residential arson, where there is a threat of personal injury or harm against a person.
3. Violation of a custody order in which the custodial parent suffers injury.

“Denial” means disqualification of an application or reduction in the amount of compensation paid.

“Department” means the department of justice, i.e., the attorney general’s office.

“Dependent” means a person who is wholly or partially reliant upon a victim for care or support and includes a child of the victim born after the victim’s death, or a person who is unable to care for himself or herself due to injury, disability, or minor age status.
“Director” means the director of the crime victim assistance division established in the department of justice.

“Division” means the crime victim assistance division of the department of justice.

“Incitement” means to urge forward or to goad to action.

“Lost wages or income,” “lost income,” or “lost wages” means the gross rate of pay, decreased by 25 percent.

“Medical care” means services provided by or provided under the supervision of a person licensed under Iowa law as a medical physician or surgeon, osteopathic physician or surgeon, chiropractor, podiatrist, physical therapist, acupuncturist, or dentist. Medical care also includes services rendered in accordance with a method of healing sanctioned by a federally recognized sovereign nation or tribe.

“Medically necessary” means that the items and services prescribed or recommended by a medical provider under the prescriptive authority of the medical provider’s license are reasonably necessary to facilitate the victim’s physical and emotional recovery from the compensable crime.

“Pecuniary loss” means the amount of medical or medical-related expenses and shall include, but not be limited to, eyeglasses, hearing aids, dentures, prosthetic devices including those which were taken, lost, or destroyed during the crime, home health care, medications, counseling, pregnancy-related services, equipment rental or purchase, property alteration, transportation for emergencies and medical care provided outside the victim’s county of residence, or health insurance premiums covered by an employer previous to the victim’s disability from the crime. Pecuniary loss shall also include the loss of income that the victim has incurred as a direct result of the injury to the extent that the victim has not been and shall not be indemnified from any other source.

“Personal injury” or “injury” means bodily harm or mental suffering and shall include a victim’s pregnancy or miscarriage resulting from a crime.

“Program” means the crime victim compensation program of the department of justice.

“Provocation” means to cause anger, resentment, or deep feelings that cause or instigate another to take action.

“Public funds” means moneys provided by federal, state, county, city or other local government.

“Reasonable charges” means charges ordinarily charged by the provider of the service to the general public for services of a similar nature.

“Residence” means a property on which an applicant lives and may include but is not limited to a dwelling, detached garage, shed, or similar structure located on the property, or a privately owned vehicle if the vehicle serves as the primary residence.

[ARC 4571C, IAB 7/31/19, effective 9/4/19]

61—9.27(915) Duties of the division. The duties of the division shall include, but not be limited to, the duties provided for in Iowa Code sections 13.31 and 915.83, as well as:

1. To prepare appropriate forms for the filing and processing of compensation applications.
2. To conduct an administrative review of claims when a request for reconsideration is filed by an applicant with the director.
3. To receive moneys bequeathed, awarded, or donated to the crime victim assistance division by a public or private organization or individual.

61—9.28(915) Application for compensation. An applicant may file an application for compensation by telephone or in writing within two years of the occurrence or discovery of a crime pursuant to Iowa Code section 915.84(1). For a victim of sexual abuse when the offender has been referred pursuant to Iowa Code chapter 229A, the date of the discovery of the crime shall be considered to be the date when the referral was made. The department may waive the requirements of Iowa Code section 915.84(1) if good cause is shown.

9.28(1) Application postmarked. An application postmarked within the prescribed time period shall be considered timely filed.

9.28(2) Good cause. In determining whether there is good cause for waiver of the two-year application filing requirement, the victim’s age, physical condition, psychological state, cultural or
linguistic barriers, and any compelling health or safety reasons that would jeopardize the well-being of the victim may be considered.

9.28(3) Multiple erroneous claims. When two or more applications are filed by or on behalf of an individual applicant during a calendar month and the applications appear on initial review to be erroneous claims based on innocent misrepresentation or circumstances of a similar nature, the claims shall be treated as a single application. Verification shall be investigated for each crime recorded in a file with multiple erroneous applications. If any of the crimes recorded in a combined application are verified as compensable crimes, the applications for compensation for those crimes shall be separated from the combined file and assigned distinct application numbers. The department will notify the applicant whenever two or more applications have been combined as one application.

9.28(4) Program effective date. The effective date of the crime victim compensation program is January 1, 1983. Victims and survivors of crimes that were committed prior to the effective date may be eligible for compensation if the program can obtain sufficient documentation to verify eligibility.

9.28(5) Concurrent primary and secondary applications. A victim may be both a primary victim and a secondary victim in the same crime. The secondary victim application shall not be opened until a benefit has been exhausted for the primary application and there is documentation of need for further benefits in that category. The secondary victim application shall be considered timely filed if the primary victim application was timely filed.

9.28(6) Concurrent secondary victim applications. A victim may be a secondary victim to multiple primary victims in a crime. A subsequent secondary victim application shall not be opened until a benefit has been exhausted in the first secondary victim application and there is documentation of need for further benefits in that category. Subsequent secondary victim applications shall be considered timely filed if the primary victim application was timely filed.

[ARC 4571C, IAB 7/31/19, effective 9/4/19]

61—9.29(915) Report to law enforcement. A person is not eligible for compensation unless the crime is reported to law enforcement pursuant to Iowa Code section 915.84(2). The department may waive the requirements of Iowa Code section 915.84(2) if good cause is shown.

9.29(1) Law enforcement report sources. The department finds there is good cause to accept that the report of a crime to any of the following is a report to law enforcement pursuant to Iowa Code section 915.84(2):

a. Sheriffs and their regular deputies.

b. Marshals and police officers of cities.

c. Peace officers of the department of public safety.

d. Special security officers employed by a board of regents institution as identified in Iowa Code section 262.13.

e. Peace officers as authorized by Iowa Code sections 350.5 or 456A.13.

f. Employees of the department of transportation who are designated “peace officers” by resolution of the department under Iowa Code section 321.477.

g. Correctional officers, including parole and probation officers.

h. County and state prosecutors.

i. An employee of the department of human services having jurisdiction to investigate the incident.

j. A magistrate or judge of the Iowa court system.

9.29(2) Elements of a report. A victim is considered to have made a report to law enforcement when the victim has provided a true and accurate report of the incident, which shall include to the best of the victim’s knowledge:

a. The nature of the crime,

b. The location of the crime,

c. The name, whereabouts and description of the suspect, if known, and

d. The names of witnesses, if known.
9.29(3) **Law enforcement record.** A law enforcement trip record may satisfy the requirement that the crime be reported to law enforcement.

9.29(4) **Good cause.** In determining whether there is good cause for waiving the requirement to report a crime to law enforcement within 72 hours of the occurrence of the crime, the victim’s age, physical condition, psychological state, cultural or linguistic barriers, and any compelling health or safety reasons that would jeopardize the well-being of the victim may be considered. In the event good cause is found, the crime must be substantiated through disclosure to another provider including, but not limited to, a licensed medical provider, a licensed mental health professional, or a designated victim service provider.

9.29(5) **Child victim.** If the victim is a child as defined in Iowa Code section 232.2 and is reported to be a victim of child abuse, the department finds there is good cause to waive the 72-hour reporting requirement.

9.29(6) **Dependent adult victim.** If the victim is a dependent adult as defined in Iowa Code section 235B.2(4) and is reported to be a victim of dependent adult abuse, the department finds there is good cause to waive the 72-hour reporting requirement.

9.29(7) **Sexual abuse victim.** For a victim of sexual abuse, the 72-hour reporting requirement may be waived for good cause if a sexual abuse evidentiary examination was completed within 72 hours of the crime or if the crime was disclosed to another provider including, but not limited to, a licensed medical provider, a licensed mental health professional, or a designated victim service provider.

9.29(8) **Domestic abuse victim.** For a victim of domestic abuse, the 72-hour reporting requirement may be waived for good cause if a domestic abuse protective order pursuant to Iowa Code chapter 236 is entered by the court or if the crime was disclosed to another provider including, but not limited to, a licensed medical provider, a licensed mental health provider, or a designated victim service provider.

9.29(9) **Victim of a sexually violent predator.** For a victim of sexual abuse, the department finds good cause to waive the 72-hour reporting requirement when the offender is referred pursuant to Iowa Code chapter 229A.

[ARC 4571C, IAB 7/31/19, effective 9/4/19]

61—9.30(915) **Cooperation with law enforcement.** To be eligible for compensation, the crime victim must cooperate with the reasonable requests of law enforcement. After considering the factors in subrule 9.29(4), the department may waive the requirement if good cause is shown.

9.30(1) **Reasonable cooperation.** Reasonable cooperation by the victim may include, but is not limited to, the following:

a. Providing law enforcement with a true and accurate report of the crime.

b. Participating in the investigation of the crime to assist law enforcement in the identification of a suspect as requested including the review of photographs, composites, and lineups.

c. Participating in prosecution procedures including deposition and trial testimony as requested.

9.30(2) **Determination of cooperation.** In determining whether a victim reasonably cooperated with law enforcement, the division may consider the victim’s age, physical condition, psychological state, cultural or linguistic barriers, and any compelling health or safety reasons that would jeopardize the well-being of the victim.

9.30(3) **Polygraph testing.** In determining whether a victim reasonably cooperated with law enforcement, the refusal of a victim to undergo a polygraph examination shall not be the basis of denial.

9.30(4) **Sexual abuse victim.** A victim of sexual abuse shall be deemed to have reasonably cooperated with law enforcement if the victim undergoes a sexual abuse evidentiary examination.

9.30(5) **Domestic abuse victim.** A victim of domestic abuse shall be deemed to have reasonably cooperated with law enforcement if a report of the crime was made to law enforcement.

[ARC 4571C, IAB 7/31/19, effective 9/4/19]

61—9.31(915) **Contributory conduct.** The division shall reduce or disqualify compensation when there is a causal relationship between the contributory conduct on the part of the victim and the victim’s injury or death. Contributory conduct includes consent, provocation, or incitement of the crime on the part of the victim.
9.31(1) Consent, provocation, and incitement. In assessing consent, provocation or incitement on the part of the victim pursuant to Iowa Code section 915.87(2) “a,” the division may consider factors including, but not limited to, the following:
   a. Whether charges are filed against the suspect;
   b. Whether the victim attempted to withdraw from the incident;
   c. Comparable or reasonable force on the part of the suspect in response to an action of the victim;
   d. The amount of time from the beginning of the interaction between the victim and the suspect and the criminal act committed by the suspect;
   e. The age of the victim; and
   f. Comparable size or strength of the victim and suspect.

9.31(2) Additional assessment of consent. In assessing the causal nature of consent pursuant to Iowa Code section 915.87(2) “a,” the division may consider the victim’s age, physical condition, psychological state, cultural or linguistic barriers, and any compelling health or safety reasons that would jeopardize the well-being of the victim.

9.31(3) Consent in intoxicated driving cases. A victim who was the passenger in the vehicle of a driver who has been determined to have been legally intoxicated at the time of the crash shall not be automatically denied eligibility for compensation. The division may consider whether the victim could have reasonably known the intoxication level of the driver, the driver’s behavior or judgment appeared impaired, the victim encouraged or discouraged the driver from driving, or the victim’s judgment was impaired.

9.31(4) Additional assessment of provocation and incitement, and commission of a criminal act. In assessing the causal nature of provocation or incitement and commission of a criminal act pursuant to Iowa Code section 915.87(2), the division may consider law enforcement documentation that indicates:
   a. Retaliatory action. The crime was committed as retaliation for a prior physical assault or injury committed by the victim against the perpetrator, and the victim could have reasonably foreseen the likelihood of retaliation.
   b. Gang action. The crime was a direct result of gang activity, including gang initiation, or was inflicted as retaliation for prior gang activity in which the victim participated in a criminal street gang as defined in Iowa Code section 723A.1(2).
   c. Mutual combat. The crime was an incident of mutual combat if the victim:
      (1) Initiated a physical altercation;
      (2) Made a credible threat of bodily harm against the person, took action to indicate the intent to carry out the threat and a physical altercation immediately followed; or
      (3) Accepted a verbal challenge to engage in a physical altercation, took action to indicate acceptance of the challenge and a physical altercation immediately followed.
   d. Exception to mutual combat. Incitement and provocation are not present in an incident of mutual combat when a significant escalation of the fight, such as the introduction of a deadly weapon, is made by a person other than the victim or when a third party becomes involved resulting in more serious injury than the victim could have reasonably expected.

9.31(5) Victim’s criminal act. Contributory conduct includes assisting in, attempting, or committing a criminal act by the victim. A causal relationship must be documented between the injury or death for which compensation is sought and the criminal act of the victim.

[ARC 4571C, IAB 7/31/19, effective 9/4/19]

61—9.32(915) Eligibility for compensation. The program shall determine the eligibility of an application for compensation.

9.32(1) Determination of eligibility. A denial of eligibility shall be based on written documentation that an application does not satisfy the requirements of Iowa Code chapter 915. An applicant shall be deemed eligible for compensation if the division has not obtained written documentation supporting a denial within six months of the date of the application. Notwithstanding the foregoing, the division may extend the determination of eligibility beyond six months if a court date or grand jury hearing is pending and is reasonably expected to result in information necessary to render an eligibility decision.
9.32(2) Reopening applications. Pursuant to Iowa Code section 915.83(2), the department may reopen and reinvestigate an application if the department determines that the decision was incorrect or incomplete. A denied application may be reopened and reinvestigated if it is discovered through a criminal trial or other investigatory source that the information relied upon for the denial decision was incorrect or incomplete. The eligibility of an approved application will be reopened for consideration if information is discovered through a criminal trial or other investigatory source that the information relied upon for the approval decision was incorrect or incomplete. The reopening of a denied or approved case is at the discretion of the administrator for the compensation program, the director, or the board.

9.32(3) Withdrawal of application. An applicant may withdraw the application for compensation from consideration.

9.32(4) Maximum compensation. Compensation shall be reduced or disqualified to the extent that the maximum compensation allowable pursuant to Iowa Code chapter 915 and these rules has been awarded.

[ARC 4571C, IAB 7/31/19, effective 9/4/19]

61—9.33(915) Emergency award of compensation. Emergency awards of compensation may be made if the applicant has incurred a loss of income or pecuniary loss as a direct result of the crime.

9.33(1) Preliminary eligibility determination. The program must determine that the application is likely to be eligible based on documentation available including, at minimum, the law enforcement verification form provided to law enforcement by the program.

9.33(2) Documentation. To make an emergency award of compensation, the program must have documentation of the lost wages or the pecuniary loss.

9.33(3) Emergency award decision. A decision denying an emergency award shall not be appealable.

9.33(4) Offset. Any emergency award shall be deducted from the final award of compensation made to the claimant.

61—9.34(915) Computation of compensation. The division shall determine the amount of compensation to be awarded to an eligible applicant.

9.34(1) Benefit limits. Compensation shall be made up to the benefit category limits in effect on the date the application is filed. For an eligible victim of sexual abuse when the offender has been referred pursuant to Iowa Code chapter 229A, compensation shall be paid for expenses incurred after referral of the offender.

9.34(2) Payer of last resort. The program is a payer of last resort pursuant to federal law 34 U.S.C. 20102. Compensation shall not be paid for services when the provision for those services is mandated by law or administrative rule to be the responsibility of another governmental unit, private agency or program. Payments shall be reduced by payments made by offenders and third parties responsible for the damages of the crime. The department may waive this requirement for good cause after considering the factors in subrule 9.29(4), for compensation made from state funds.

9.34(3) Voluntary financial programs. Compensation applicants will be encouraged to apply for other financial assistance programs to pay costs resulting from the crime-related injury. However, no applicant will be denied compensation benefits based on the applicant's refusal to seek funds from a voluntary financial assistance program.

9.34(4) Insurance providers. Eligible victims and claimants must give service providers the information necessary to bill insurance providers for crime-related treatment. Payment of compensation will not be made if the victim refuses or fails to provide information requested by the service or insurance provider or to sign the required assignment of benefits within a reasonable time frame. The department may waive this requirement if the victim can demonstrate good cause exists. Good cause may include, but is not limited to, situations where the insurance policyholder is the perpetrator of the crime that gave rise to the claim.

9.34(5) Supplanting of funds prohibited. Compensation shall be made only when the claimant is responsible for the cost of crime-related injury. Compensation shall not be paid when a government
entity, including but not limited to a mental health facility, jail, or prison, is responsible for the costs of treatment for injury from crime, unless the entity is legally allowed to pass those costs along to the victim.

[ARC 4571C, IAB 7/31/19, effective 9/4/19]

61—9.35(915) Computation of benefit categories. The division shall determine the amount of compensation to be awarded to an eligible applicant for injury from crime for each benefit category pursuant to Iowa Code section 915.86.

9.35(1) Medical care. Compensation may be paid for the reasonable expenses of medical care provided to eligible crime victims by, or under the supervision of, a person licensed by the state under Iowa Code chapter 147, 148, 148A, 149, 150A, 151, 152C, or 153. When preexisting medical conditions are treated during crime-related medical care, the program may reduce payment to a percentage equal to the portion of the medical care determined to be directly related to the compensable crime. Medical care expenses include the following:

a. Medical care sanctioned by sovereign nations and tribes. Compensation may be paid for medical care rendered in accordance with a method of healing sanctioned by a state-recognized or federally recognized sovereign nation or tribe.

b. Medical counseling costs. Compensation may be paid for counseling provided under the direct supervision of a psychiatrist or other physician and shall be applied toward the medical benefit maximum.

c. Medical care for homicide victim survivors. Compensation may be paid to the spouse, child, parent, sibling, or person related by blood or affinity to a homicide victim for the same types of medical care which are allowable for primary victims, including but not limited to hospital and physician care, psychiatric care, prescriptions, and transportation expenses related to injury from the crime.

d. Medical equipment and property alteration. Compensation may be paid for equipment and property alteration which are prescribed as medically necessary care due to injury from the crime.

e. Medical supplies. Compensation may be paid for medical care supplies and incidental supplies necessary for medical care due to injury from the crime.

f. Medical care for pregnancy. Compensation may be paid for medical care costs related to pregnancy resulting from the crime of sexual abuse. Eligible expenses for care of the victim shall be paid. Expenses incurred for care of a newborn child are not compensable.

g. Medical devices. Compensation may be paid for the replacement of a medical device including but not limited to a sight or hearing device, dentures, prosthetic device, wheelchair, and medication that was taken, lost or destroyed during the crime.

h. Transportation for medical emergency. Compensation may be paid for the reasonable cost of transportation in a medical emergency by private vehicle at the per-mile rate established by the department of administrative services for state employees using a privately owned vehicle for state business. Mileage will be based on mileage calculation from the most current map published by the department of transportation. Transportation within a city limits will be based on the program’s estimate of mileage from the location of the injured victim to the medical facility.

i. Transportation for nonemergency care. Compensation may be paid for the cost of transportation by commercial vehicle or by private car for nonemergency medical care and counseling received outside of the victim’s county of residence. Transportation provided by private vehicle for nonemergency care will be reimbursed at the per-mile rate established by the department of administrative services for state employees using a privately owned vehicle for state business. Mileage will be based on mileage calculation from the most current map published by the department of transportation.

j. Transportation medical benefit. Compensation may be paid for transportation from the applicable medical care or counseling benefit category. The available funds to the victim from the applicable benefit category will be reduced by the amount of compensation paid for transportation.

k. Health insurance. Compensation may be paid for premiums to continue a health insurance policy that was provided in whole or in part by the victim’s employer prior to the crime and the employment ceased as a result of the crime.
9.35(2) Medical care records. When compensation for medical care is requested, the provider shall submit medical records that document the care provided and show that the medical care is for injury from crime.

9.35(3) Mental health counseling. Compensation may be paid for the reasonable costs of up to 12 mental health counseling sessions for eligible crime victims and survivors of a homicide victim with the provision of a treatment plan and certification as defined in paragraph 9.35(4)“a.” Costs for those 12 sessions will be paid in full if the crime is noted in the treatment plan. If preexisting mental health issues are addressed during crime-related counseling sessions following the initial 12 visits, the program may reduce payment to a percentage equal to the portion of the counseling determined to be directly related to the compensable crime. The mental health counseling provider shall submit a vitae establishing the provider’s educational qualifications for compensation. A provider who is required to be licensed under Iowa law must provide proof of licensure and good standing with the professional licensing board. Compensation shall be paid for mental health counseling provided by the following:

a. Master’s level counselor. Compensation may be paid for mental health counseling provided by a person holding at least a master’s degree in a mental health or counseling field including but not limited to social work, psychology, guidance and counseling, behavioral sciences, art therapy, marriage and family therapy, child life therapy, and advanced mental health registered nursing.

b. Supervised mental health counselor. Compensation may be paid for mental health counseling provided by a counselor who does not have a master’s degree but is under the supervision of a counselor with a master’s degree. The supervising mental health counselor must sign the session notes which must be submitted for review by the program.

c. Intern mental health counselors. Compensation may be paid for mental health counseling provided by an intern candidate for a master’s degree when the counseling is provided within a course of professional education and the intern is supervised by a provider eligible for compensation.

d. Out-of-state providers. Compensation may be paid to mental health counselors outside Iowa who provide services to victims of crime eligible for the Iowa program if the mental health counselor meets the professional licensure criteria of the state in which the counselor works.

9.35(4) Mental health counseling records. When compensation for mental health counseling is requested, the provider shall complete verification forms related to the counseling as follows:

a. Treatment plan and certification form. Information submitted on the treatment plan and certification form shall include, but not be limited to, a summary of the initial evaluation, any preexisting mental health diagnoses currently being treated, current diagnoses, issues addressed, counseling goals, expected length of counseling services, and certification of the percentage of mental health counseling directly related to issues arising from the victimization.

b. Treatment progress and certification form. At six-month intervals for the duration of the crime-related mental health counseling, the provider shall submit a treatment progress and certification form. Information on the form shall include progress on previously stated goals of counseling, current goals, current diagnosis, expected length of additional counseling, and certification of the percentage of mental health counseling directly related to issues arising from the victimization.

c. Session notes. The program may require submission of session notes to determine if the mental health counseling is directly related to the crime when:

(1) The counseling expenses for a victim exceed $3,000.
(2) The provider has not completed the treatment and certification plan with statement of the percentage of treatment directly related to the crime.
(3) The counseling begins, or is provided, more than one year after the crime.
(4) The treatment plan or progress summary indicates that the victim is receiving treatment for a diagnosis or issue not exacerbated by the crime.

9.35(5) Counseling with the perpetrator. Compensation for mental health counseling that includes the perpetrator of the crime may be payable when the perpetrator takes part to take responsibility for the crime and apologize to the victim and the victim is allowed to confront the perpetrator regarding the effects of the crime; or at the request of the victim.
9.35(6) **Family counseling.** Compensation for family mental health or victim service counseling may be paid only for sessions where the victim is present and the focus of the session is to assist the victim in recovery from a compensable crime.

9.35(7) **Lost wages or income.** Compensation may be paid for reasonable lost wages or income when an eligible crime victim is unable to work as the result of physical or emotional injury from a crime, as a result of cooperation with the investigation or prosecution of the crime, or due to health and safety concerns related to maintaining employment. Lost wages or income are computed as the gross rate of pay multiplied by the number of scheduled hours of work missed, decreased by 25 percent pursuant to the definition of “lost wages or income” in rule 61—9.26(915). Lost wages or income due to the crime is determined as follows:

a. **Variable income.** Income that is variable shall be computed based on the average income earned during a minimum 28-day period within the three months preceding the crime. Estimated earnings not supported by past income statements shall not be accepted.

b. **Self-employment and small business income.** Self-employed persons or small business employees must provide federal or state income tax forms for the most recent year completed or verification of average income for a minimum of the past six months. Work estimates, labor contracts, and affidavits from individual employers may be used to establish wages.

c. **Vacation, sick, holiday, bereavement, and annual leave.** Lost wages or income paid shall not be reduced by vacation, sick, holiday, bereavement, or annual leave available or used by the victim due to the crime.

d. **Calculation when rate of pay cannot be established.** In the event employment can be verified but the rate of pay cannot be established through pay stubs, state or federal tax forms, or bank statements, compensation shall be calculated at the current state minimum wage rate on the basis of an eight-hour workday.

9.35(8) **Lost wages or income as the result of physical or emotional injury from a crime.** Compensation for lost wages or income incurred within the first two weeks following the crime shall be paid to an eligible crime victim without an authorized disability statement. Compensation for lost wages or income incurred within the first 30 days following the crime may be paid to an eligible survivor of a deceased victim without a disability statement. A victim seeking lost wages for a period of time longer than two weeks, or an eligible survivor seeking lost wages for longer than 30 days under Iowa Code section 915.86(10), shall submit a disability statement from a licensed medical provider for a physical injury or an injury related to mental health, or from a licensed mental health provider as included in paragraphs 9.35(3)“a” through “d” for an injury related to mental health. Compensation shall be made for lost wages or income under the following circumstances:

a. **Lost income.** Compensation may be paid when the victim misses work due to physical or emotional injury from crime.

b. **Lost hire income.** Compensation may be paid when the victim has been hired by an employer but is unable to begin employment because of injury due to the crime, until released to work. Required documentation includes a signed affidavit by the employer.

c. **Employment ceases.** Compensation may be paid when the victim’s employment ceases as a result of crime-related injuries, until released to seek work.

d. **Unemployment eligible.** Compensation may be paid for the difference between the victim’s lost wages or income and the unemployment benefit when the victim is terminated from employment because of injury from crime and is found to be eligible for unemployment benefits.

e. **Unemployment ineligibility.** Compensation may be paid for the amount of the victim’s unemployment benefit when the victim is rendered ineligible for unemployment benefits because of injury from the crime, until the victim is released to work.

f. **Workers’ compensation benefit eligible.** Compensation may be paid for the difference between the victim’s gross wage and the workers’ compensation benefit when the victim is unable to work because of injury from crime and is found to be eligible for workers’ compensation benefits.
g. Medical and counseling appointments. Compensation may be paid to a primary victim, the parent or guardian of a minor aged primary victim, or the caretaker of a dependent adult primary victim for wages lost due to medical care or counseling appointments for the victim.

9.35(9) Lost wages or income for cooperation in an investigation and prosecution. Compensation may be paid for lost wages or income incurred by an eligible primary victim, survivor of a deceased victim as described in Iowa Code section 915.86(8), parent or guardian of a minor aged primary victim, or caretaker of a dependent primary victim while cooperating with the investigation and prosecution of the crime including, but not limited to, participation at identification sessions, arraignment, deposition, plea agreement meetings, trial, sentencing, parole and probation hearings, and sexually violent predator civil commitment proceedings.

9.35(10) Lost wages or income due to health or safety concerns related to maintaining employment. Compensation for lost wages or income shall be paid to an eligible crime victim for up to 30 days following an event that compromises the health or safety of the victim including, but not limited to, the approved crime, stalking, or harassment. Compensation for lost wages or income beyond 30 days may be extended at the discretion of the program administrator, the director, or the board.

9.35(11) Residential crime scene cleanup. Compensation may be paid for the reasonable costs of an eligible victim or applicant for cleaning a residential crime scene, which includes a home, or a private vehicle if the vehicle serves as the primary residence, in which the crime was committed. Cleaning a residential crime scene means to remove, or attempt to remove, from the crime scene blood, dirt, stains, or other debris caused by the crime or the processing of the crime scene. Compensation shall be paid for the reasonable out-of-pocket cost of cleaning supplies, equipment rental, labor, and the value of property which is essential to the victim and which is held by law enforcement for evidentiary purposes. Cleaning a residential crime scene does not include replacement or repair of property damaged in the crime.

9.35(12) Loss of support. Compensation for loss of support may be paid for the dependents of an eligible homicide victim or of a victim disabled for a period of 60 days or more when the applicant documents that the dependent relied on the victim wholly or partially for physical care or financial support.

   a. Period of dependency. Compensation may be paid for loss of support for the remaining period of dependency, up to the limits established in Iowa Code section 915.86(5), in an amount equal to the lost wages or income the victim was earning at the time of death or disability. The amount of compensation shall be subject to reduction by the amount of collateral sources designated as support pursuant to Iowa Code section 915.87(1).

   b. Dependent care. Compensation may be paid for loss of support at the current hourly rate of the Iowa minimum wage for dependent care provided by a person other than the victim if the victim was providing physical care to the dependent at the time of the crime.

9.35(13) Clothing and bedding. Compensation may be paid for clothing and bedding held as evidence by law enforcement. Compensation shall not be made for a deceased victim’s clothing which is held as evidence.

9.35(14) Funeral, burial, and memorial expenses. Compensation may be paid for reasonable expenses incurred for the funeral and burial or cremation for an eligible crime victim. The following expenses may be paid up to the maximum expense established in Iowa Code section 915.86(6):

   a. Funeral service. Compensation may be paid for expenses related to funeral and burial or cremation preparation and services.

   b. Burial plot and vessel. Compensation may be paid for the cost of a burial plot, vault, casket, urn, or other permissible vessel.

   c. Burial effects. Compensation may be paid for miscellaneous funeral and burial expenses including, but not limited to, flowers, burial clothing for the victim, transportation of the victim’s body, and travel and lodging expenses for survivors of the deceased victim as described in Iowa Code section 915.80(7) with priority for the surviving spouse, children, and parents of the victim. Documentation must be provided for all miscellaneous funeral and burial expenses.

   d. Memorial. Reasonable memorial costs may be paid for commemorating the memory of a deceased victim, including but not limited to a structure or public or private event.
9.35(15) Dependent care. Compensation may be paid for reasonable costs of dependent care incurred by a primary victim, the parent or caretaker of a dependent primary victim, or the survivor of a deceased victim, to attend medical or counseling appointments or criminal justice proceedings. Dependent care expenses may be paid for the parent or caretaker of a primary victim to attend the parent’s or caretaker’s own medical or mental health appointments.

Compensation may include, but is not limited to, expenses for care provided by a day care center, private residential childcare, relative who is not a tax dependent, before- or after- school program, custodial elder care, adult day care center, nanny, or au pair. Expenses may be paid up to the maximum benefit established in Iowa Code section 915.86(13).

9.35(16) Residential security. Compensation may be paid for reasonable costs incurred by a victim, the victim’s parent or caretaker, or the survivor of a deceased victim to install new residential security items, or to replace inadequate or damaged residential security items, not to exceed the maximum expense established in Iowa Code section 915.86(14).

Compensation may be paid for doors, locks, windows, security cameras, security systems or devices, or other reasonable expenses that provide for the safety of the victim or the security of the residence.

9.35(17) Transportation and lodging expenses. Compensation may be paid for reasonable transportation and lodging expenses incurred by the victim, secondary victim, parent or guardian of the victim, or the survivor of a deceased victim for medical and counseling services, criminal justice proceedings, or funeral activities, not to exceed the benefit limit established in Iowa Code section 915.86(15).

a. Privately owned vehicle. Use of a privately owned vehicle shall be paid at the per-mile rate established by the department of administrative services for state employees using a private vehicle for state business.

b. Commercial vehicle transportation shall be paid at the cost incurred by, or on behalf of, an eligible applicant.

[ARC 4571C; IAB 7/31/19, effective 9/4/19]

61—9.36(915) Appeal of compensation decisions. An applicant shall be informed in writing of the basis for the denial of eligibility or the amount of an award.

9.36(1) Applicant appeal. An applicant may appeal a compensation decision as follows:

a. Appeal to director. An applicant aggrieved by a denial decision or the amount of compensation awarded by the program may appeal to the director.

b. Appeal to board. An applicant may appeal the director’s decision to the board.

c. Appeal to district court. An applicant who disagrees with the decision of the board has the right to appeal to the district court for judicial review within 30 days of receipt of the board’s decision.

9.36(2) Director appeal period. An applicant shall submit to the director a written request for reconsideration within 30 days of the date the notice of the crime victim compensation program decision is mailed or otherwise issued by the division. Any request for reconsideration postmarked within the prescribed time period shall be considered timely filed by the division. Barring any unusual circumstances, within 30 days of the receipt of the request for reconsideration, the director shall issue a decision.

9.36(3) Board appeal period. An applicant may file with the board a request for consideration of the director’s decision. This written request for consideration by the board shall be submitted within 30 days of the date the notice of the director’s decision is mailed or otherwise issued by the director. Any request for review postmarked within the prescribed time period shall be considered timely filed by the division. Barring any unusual circumstances, within 90 days of the receipt of the request, the board, or a committee designated by the chair of not fewer than five members of the board, shall issue a decision.

9.36(4) District court appeal period. An applicant shall submit a petition for judicial review to the district court within 30 days of the receipt of the notice of the board’s decision.

61—9.37(17A) Waiver from rules. This rule establishes a uniform process for granting waivers from rules adopted by the board governing the crime victim compensation program.
9.37(1) When waiver is appropriate. The board may grant a waiver from a rule the board has adopted if the board has rule-making authority to promulgate the rule, and no statute or rule otherwise controls the granting of a waiver from the rule. No waiver may be granted from a rule that defines a term. No waiver may be granted from a requirement that is imposed by statute. Any waiver must be consistent with statute.

9.37(2) Criteria for discretionary waivers. The board may grant a waiver from a rule, in whole or in part, in response to a request from an applicant or on the board’s own motion, as applied to a specific claim, if the board finds that:
   a. The application of the rule to the claim at issue would result in hardship or injustice to the person seeking compensation; and
   b. The waiver would be consistent with the public interest or the public interest will be protected by other means substantially equivalent to full compliance with the rule; and
   c. The waiver in the specific case would not prejudice the substantial legal rights of any person.

9.37(3) Board discretion. The decision about whether the circumstances justify the granting of a waiver shall be made at the sole discretion of the board, upon consideration of all relevant factors.

9.37(4) Criteria for mandatory waivers. In response to an applicant’s request, the board shall grant a waiver from a rule, in whole or in part, as applied to the particular circumstances, if the board finds that the application of the rule in that specific case would not, to any extent, advance or serve any of the purposes of the rule.

9.37(5) Administrative deadlines. When the rule from which a waiver is sought establishes deadlines, the board shall balance the specific individual circumstances of the applicant with the overall goal of uniform treatment of all applicants.

9.37(6) Conditions. The board may condition the granting of a waiver on reasonable conditions to achieve the objectives of the particular rule in question through alternative means.

9.37(7) Public availability of waiver decisions. A board decision granting or denying a waiver shall be included in the board minutes with reference to the following:
   a. The particular case and the rule or portion thereof to which the decision pertains;
   b. The relevant facts and reasons upon which the action is based; and
   c. The scope and operative period of the waiver if one is issued.

Subject to the provisions of Iowa Code section 17A.3(1)”e,” the department shall maintain a record of all orders granting and denying waivers under this chapter. All waiver decisions shall be indexed and available to members of the public at the crime victim assistance division office.

9.37(8) Voiding or cancellation. A waiver is void if the material facts upon which the request is based are not true or if material facts have been withheld. The board may at any time cancel a waiver upon notice to the victim by regular mail and an opportunity to be heard, if:
   a. The facts as stated in the request are not true or material facts have been withheld, or
   b. The applicant has failed to comply with the conditions of the waiver.

9.37(9) Effectiveness of waiver. After the board issues a waiver, a person seeking compensation may rely on the terms of that waiver for the purposes of the particular case for which it was issued. A waiver shall only be effective in the case for which it is issued.

9.37(10) Appeals from waiver decisions. Any request for an appeal from a decision granting or denying a waiver shall be in accordance with the procedures provided in Iowa Code chapter 17A and the board’s rules. An appeal shall be taken within 30 days of the issuance of the waiver decision unless a contrary time is provided by rule or statute.

These rules are intended to implement Iowa Code sections 915.80 through 915.94.
DIVISION III
VICTIM SERVICES GRANT PROGRAM

61—9.50(13) Administration of the victim services grant program. The victim services grant program of the Iowa department of justice shall administer the victim services grants as provided in Iowa Code chapters 13 and 236. All questions, comments, requests for information, or applications for grant funds shall be directed to the victim services grant program. Requests should be addressed to: Crime Victim Assistance Division, Iowa Department of Justice, 321 East 12th Street, Lucas State Office Building, Ground Floor, Des Moines, Iowa 50319, telephone (515)281-5044.

61—9.51(13) Definitions. As used in this chapter:

“Applicant” means a public or private nonprofit program that provides direct services to crime victims or training and technical assistance to crime victim service providers and that makes a request for funds from the victim services grant program.

“Application” means a request which complies with federal and state requirements for funds from the following funding streams:
2. The state domestic and sexual abuse program funds provided for in Iowa Code chapter 236.
5. Other grants or funds available by law for crime victim assistance.

“Board” means the crime victim assistance board.

“Competitive grant” means a grant for which the division solicits a request for proposals (RFP) from eligible applicants, reviews the applications for eligibility and completeness, and then convenes a grant review committee to recommend grant awards to the crime victim assistance board.

“Crime victim center” means a crime victim center as defined in Iowa Code section 915.20A(1).

“Department” means the Iowa department of justice.

“Director” means director of the crime victim assistance division of the Iowa department of justice.

“Division” means the crime victim assistance division of the Iowa department of justice.

“Focus grant” means a one-time grant for specific activities, including but not limited to training, travel, or materials, awarded at the discretion of the division directly to a program that has received a competitive grant in the fiscal year.

“Funding stream” means a distinct source of federal or state funding available for grants.

“Grant” means a competitive or focus grant award to a local or statewide government or private nonprofit agency.

“Grantee” means a local or statewide government or private nonprofit agency that is awarded or receives funds from the crime victim assistance division.

“Grant review committee” means a division committee designated to review grant applications.

“Justice support” means duties performed in the justice system related to investigation, prosecution, or disposition of a criminal case that assist or inform a victim of crime.

“Program” means the victim services grant program of the Iowa department of justice.

“RFP” means request for proposals.

“Victim” means a crime victim as defined in Iowa Code section 915.80.

61—9.52(13) Program description. Any eligible local or statewide government or private nonprofit agency or a combination thereof may apply for and receive a grant through the program. The program shall operate as a competitive and focus grants program and be administered by the department. A contractual agreement specifying the terms of the grant award shall be executed between the department and the approved applicant.

61—9.53(13) Availability of grants. In any year in which federal or state funds are available, the division shall administer grants with eligible applicants. The amount of the funds awarded shall be contingent upon the funds available. The director shall announce the opening of an application period
through public notice including but not limited to notice to current grantees and other eligible agencies identified by the program. Applications must be received by the designated due date.

9.53(1) Competitive grants will be awarded based on the availability of funds, history and demonstration of quality of services provided, compliance with the requirements of the division, number of victims served or cases investigated and prosecuted, population served, and geographical distribution of funds in the state. A preference shall be given to continued funding of successful grantees.

9.53(2) Focus grants will be awarded at the discretion of the director and of the deputy attorney general who oversees the division. Funds utilized for focus grants must comply with all applicable state and federal rules and regulations. The total of focus grants from one funding source may not exceed 3 percent of the funds available from the funding source in one state fiscal year.

61—9.54(13) Application requirements. Applicants shall submit applications to: Crime Victim Assistance Division, Iowa Department of Justice, 321 East 12th Street, Lucas State Office Building, Ground Floor, Des Moines, Iowa 50319. Applications shall be in the form prescribed by the division and shall be available upon request to all interested parties.

9.54(1) To be included in the review process and considered for funding, an application shall be received in the offices of the division by 4:30 p.m. on the due date. Applications may be delivered to the division during regular business hours anytime prior to the deadline. An extension of the filing deadline may be requested of the director or grant administrator prior to the deadline and may be granted for good cause. The determination of a good cause extension by the division director shall be final.

9.54(2) An applicant shall have on file with the division current copies of the applicant’s table of organization and articles of incorporation as required.

9.54(3) An applicant shall have on file with the division evidence of any insurance coverage the applicant carries for liability or property.

9.54(4) The division may allow combined applications from two or more agencies if a combined application will encourage cooperation between those agencies on behalf of crime victims. Each agency receiving funds under a combined application shall sign a grant contract for the use of awarded funds.

61—9.55(13) Contents of application. Each application shall contain the following information:

9.55(1) A paragraph describing the agencies or units of government requesting the funds.

9.55(2) A description of services for which funding is being requested. The description shall include, but not be limited to, the following:

a. The geographical area to be served.
b. The crime victim population to be served.
c. Victim eligibility requirements for the applicant’s services.
d. A description of substantial financial support from other sources.
e. The intended use of volunteers, if any.
f. The stated goals and objectives of the program.
g. A description of the proposed victim service, training, or technical assistance to be implemented during the funding year.
h. The amount of grant funds requested.
i. The amount of cash or in-kind resources or combination thereof which is committed where required by the division.
j. A description of how the proposed victim service, training, or technical assistance will provide or improve services to victims of crime.
k. Proof of coordination with appropriate agencies at the local level.
l. A total program budget for all services provided by the applicant’s crime victim program.
m. A proposed budget for the requested grant funds.
n. A list of other anticipated sources of income, including written commitments, if possible, and plans for continued funding of the grant-funded activities.
o. Other information identified in the RFP.
p. Signed certified assurances as required by statute or regulation.
61—9.56(13) Eligibility requirements. Funds must be used only to provide victim services, or justice support to victims of crime, and training or technical assistance to victim service providers and allied professionals. Program grants shall not be used to supplant other available or mandated funds. An applicant must meet the following requirements:

9.56(1) The applicant shall be a public agency or private nonprofit organization, or combination thereof, that provides services to crime victims or training and technical assistance to victim service providers and allied professionals.

9.56(2) The applicant shall provide services to victims of crime through crime victim centers, law enforcement officers, prosecutors, and other allied professionals. Services provided to victims by crime victim centers shall include but are not limited to crisis intervention, law enforcement and court advocacy, group and individual follow-up counseling, transportation, and information and referral.

9.56(3) An applicant providing services to victims of domestic abuse must also provide or arrange safe shelter for victims and their children when needed at no cost to the victims. To ensure staff training and best practice standards, preference will be given to domestic abuse programs certified by the Iowa Coalition Against Domestic Violence.

9.56(4) An applicant providing services to victims of sexual abuse must also provide support to victims at the time of an evidentiary sexual abuse examination. To ensure staff training and best practice standards, preference will be given to sexual abuse programs certified by the Iowa Coalition Against Sexual Assault.

9.56(5) The applicant shall promote within the community a coordinated public and private effort to assist victims.

9.56(6) The applicant shall be an equal-opportunity employer and provide services on an equal-opportunity basis.

9.56(7) The applicant shall comply with applicable federal and state statutes and rules, all requirements specified in the grant between the department and any outside funding source, and all requirements in the RFP or any other contractual document.

9.56(8) The applicant shall assist victims in seeking state compensation benefits.

9.56(9) The applicant shall have a grievance procedure established for victims, employees and volunteers.

9.56(10) The applicant shall ensure that all employees and volunteers of crime victim centers that provide direct services to victims are trained as victim counselors as defined in Iowa Code section 915.20A.

9.56(11) The applicant shall provide services within the geographical service area without regard to a victim’s ability to pay.

9.56(12) An existing program must document results of prior programming that demonstrate that the needs of victims have been met effectively and that the applicant has financial support from other sources.

61—9.57(13) Selection process. The division shall conduct a preliminary review of each application to ensure that the applicant is eligible, the application is complete, and the proposed victim service, training or technical assistance is consistent with the division’s mission of providing quality assistance to crime victims and crime victim programs throughout the state.

9.57(1) In selection of competitive grantees, the division may utilize generally accepted methods of grant review including but not limited to checklists, quality scales, written comments by grant review committee members, and formulas based on past funding, population, clients served and available funds.

9.57(2) In selection of competitive grantees, the division shall establish a grant review committee. The committee shall submit recommendations for grant awards to the director. The director shall submit to the board the recommendations of the grant review committee and any alternative recommendations by the program staff.

a. The committee shall be comprised of representatives from the crime victim assistance board and experts in the fields of victim services, grant administration and management, and criminal justice.
b. The division shall provide the committee with information related to the applicant’s performance with previous grants, the quality and quantity of services provided, and community support for the applicant.

c. The committee shall review the content of the grant applications and information provided by the division and members of the committee regarding the applicant and the geographical area to be served.

9.57(3) The board shall consider the recommendations of the grant review committee and the director to determine final competitive grant awards to the extent that funds are available and to the extent to which applications meet the RFP criteria. The board may reject any or all applications.

9.57(4) In selection of grantees for a focus grant, a written proposal shall be solicited from current grantees. Interested grantees shall submit a proposal to the director outlining the purpose, cost, and outcome of the proposed grant. The director shall submit a recommendation to the deputy attorney general for criminal justice who shall make a final decision based on the availability of funds and the merits of the proposal.

61—9.58(13) Notification of applicants. An applicant shall be notified within 90 days after the application due date whether the application has been denied or approved by the board and the amount of funds approved for the application.

61—9.59(13) Request for reconsideration.

9.59(1) An applicant may file with the board a request for reconsideration of the denial of or of the amount of an award. The request for reconsideration must be submitted within ten working days of the date the notice of decision is mailed or otherwise issued by the director to the grantee. The request must state grounds for reconsideration. The board or a committee designated by the board chairperson shall review the request in a timely manner. A decision of the board or designated committee shall constitute final agency action.

9.59(2) At the time a request for reconsideration is received by the director, notice that a request for reconsideration has been filed shall be sent to all approved applicants whose funds may be affected by the request.

9.59(3) Funds shall not be disbursed pending a request for reconsideration to the extent that the funds are affected by the outcome of the request. Every applicant that would be adversely affected shall be notified if a request for reconsideration is approved, and grant awards shall be reduced as necessary.

61—9.60(13) Contract agreement.

9.60(1) A contract shall be negotiated by the department and the applicant.

9.60(2) Prior to entering into a contract, the department or the board may require modification of the proposed program, submission of further information or documents, or other stipulation of the applicant. The required modification, information, document, or stipulation shall be specified in the notification of grant award.

9.60(3) The applicant or the department may request a modification of the program budget to reflect the amount, expenses and activities allowed by the grant award. Both parties must agree to any modification of the grantee program budget.

9.60(4) In the event of a state, federal, or other audit, the grantee shall be responsible for the audit and liable for payment of any funds required to conduct the audit, to compensate for any grant disallowance, or to repay any funds received or spent contrary to the contract, these rules, or applicable law.

9.60(5) Funds shall be spent to meet the program proposals as provided in the contract. Expenditures shall be reimbursed pursuant to regular reimbursement procedures of the state of Iowa.

9.60(6) The grantee shall sign the certified assurances for the grant program at the time of application and at any time requested by the division.

9.60(7) Nothing in these rules shall be construed as limiting the remedies available to the state or the program for improper use of grant funds or other breach of the grantee’s duties under the contract and applicable law.
61—9.61(13) Performance reports. Performance reports shall be submitted to the division from all grantees. Failure to submit reports by the due date shall result in suspension of financial payments to the grantee by the program until such time as the report is received. Delinquent or inadequate reports from prior grants may detrimentally influence the award of grants for the following year.

61—9.62(13) Termination. Contracts may be terminated for the following reasons:

9.62(1) Termination by grantee. The grantee may terminate the contract at any time during the contract period by providing notice to the division.

9.62(2) Termination by department. The department may terminate a contract upon a ten-day notice when the grantee or any of its subcontractors fail to comply with the grant award stipulations, standards or conditions. The department may terminate a contract when there is a reduction of funds by executive order or otherwise.

9.62(3) Termination for cause. If the grantee fails to fulfill its obligations under the agreement properly or on time, or otherwise violates any provision of the agreement, the board may terminate the agreement by written notice to the grantee. The notice shall specify the acts or omissions relied on as cause for termination. All finished or unfinished products and services provided by the grantee shall, at the option of the department, become state property. The department shall pay the grantee fair and equitable compensation for satisfactory performance prior to receipt of notice of termination minus any funds owing to the department, e.g., damages for breach, improperly spent funds.

61—9.63(13) Financial statement supplied. Within 45 days of the termination, the grantee shall supply the department with a financial statement detailing all costs incurred up to the effective date of the termination.

61—9.64(13) Indemnification. The grantee shall defend, indemnify, and hold harmless the state of Iowa, its officers, agents and employees and any of the state’s federal funding sources for:

1. Grantee’s performance or nonperformance of a contract entered into or violation of these rules.

2. Grantee’s activities with subcontractors and all other third parties, or any other act or omission by a grantee, its agents, officers, and employees.

61—9.65(13) Records. Grantees shall keep statistical records of services provided and any other records as required by the division. The division shall have immediate access during working hours to records pertaining to the contract. No notice need be provided the grantee prior to inspection of the records.

These rules are intended to implement Iowa Code section 13.31.

61—9.66 to 9.79 Reserved.

DIVISION IV
SEXUAL ABUSE EXAMINATION PAYMENT
[Prior to 8/8/90, see Public Health Department 641—Chapter 8]

61—9.80(915) Administration of sexual abuse examination payment. The crime victim assistance program of the department of justice shall administer the sexual abuse examination program as provided in Iowa Code section 915.41. That section states in part:

“The cost of a medical examination for the purpose of gathering evidence and the cost of treatment for the purpose of preventing sexually transmitted disease shall be borne by the department of justice.”

Requests for payment should be addressed to: Sexual Abuse Examination Payments, Crime Victim Assistance Division, Lucas State Office Building, Ground Floor, 321 East 12th Street, Des Moines, Iowa 50319; telephone (515)281-5044 or 1-800-373-5044.


“Administration” means administrator of the crime victim assistance program established in the department of justice.

“Board” means crime victim assistance board.
“Department” means the Iowa department of justice.
“Eligible claimant” means a medical provider that provides a sexual abuse examination to a sexual assault victim. The following are eligible to file a claim with the crime victim assistance program in the event that they have made payment to a medical provider for the costs of a sexual abuse examination:
1. A victim of sexual abuse.
2. A person responsible for the maintenance of a sexual abuse victim.
3. A dependent of a victim who has died as a result of injuries sustained in a sexual assault.
4. The guardian of a sexual abuse victim.
“Reasonable charges” means those ordinarily charged by the provider of the service to the general public for services of a similar nature.
“Sexual abuse” means sexual abuse as defined in Iowa Code sections 709.1 and 726.2.
“Sexual abuse examination” means a medical examination provided to a woman, man, or child to collect evidence of sexual abuse victimization of that person as defined in Iowa Code sections 709.1 and 726.2 and provide treatment for the prevention of sexually transmitted disease pursuant to Iowa Code section 915.41. When applicable, the provider of a sexual abuse examination shall file a child abuse report with the Iowa department of human services as required by Iowa Code section 232.70.

61—9.82(915) Application for sexual abuse examination payment.

9.82(1) Consideration for payment. The department will consider payment upon receipt of a claim for reimbursement from a medical provider indicating that the claim is for the collection of evidence by sexual abuse examination. In the case that a victim, guardian of a victim, person responsible for the victim, or dependent of a victim who died of injuries sustained in a sexual assault has paid part or all of the charges incurred, a copy of the provider bill and documentation of personal payment of the bill must be submitted for reimbursement. An application for sexual abuse examination payment must include the federal identification number or social security number of the claimant.

9.82(2) Application filing. To apply for payment under the sexual abuse examination program, the form or bill submitted must identify the sexual assault victim by name, birth date, and patient number, indicate that the claim is for a sexual abuse examination, and itemize all services rendered and the fee for each service.


9.83(1) Payment for examination. The department shall make payment for sexual abuse examinations, as appropriate, for services including, but not limited to:

a. Examiner’s fee:
   (1) To collect the patient’s medical history;
   (2) To conduct a physical examination;
   (3) To collect laboratory specimens;
   (4) To test for sexually transmitted diseases.

b. Treatment for the prevention of sexually transmitted disease.

c. Examination facility, including:
   (1) Emergency room, clinic room or office room fee;
   (2) Pelvic tray and medically required supplies;
   (3) Additional facility or equipment fees which the department determines to be reasonable.

d. Laboratory collection and processing of specimens for: criminal evidence; sexually transmitted disease; and pregnancy testing.

9.83(2) Provider payment. The department will pay up to $300 for the examination facility and up to $200 for examiner fees. Any charges in excess of these amounts will require additional documentation from the provider. The department shall set reasonable payment limits for treatment, including prescription drugs, for the prevention of sexually transmitted diseases and for laboratory collection and processing of specimens. The crime victim assistance program will pay only those charges determined by the department to be reasonable and fair.
9.83(3) Examination kits available at no cost. The Iowa department of public safety division of criminal investigation makes sexual abuse examination kits available to health care providers at no cost. [ARC 4571C, IAB 7/31/19, effective 9/4/19]

61—9.84(915) Victim responsibility for payment. A victim of sexual abuse is not responsible for the payment of the costs of a sexual abuse examination determined to be eligible for payment by the department. A medical provider must not submit any costs associated with a sexual abuse examination to a victim’s insurance or to the sexual abuse victim. A medical provider must not submit any remaining balance to the sexual abuse victim after the sexual abuse examination program has determined payment. [ARC 4571C, IAB 7/31/19, effective 9/4/19]

61—9.85(915) Sexual abuse examination—right to restitution. In all criminal cases under Iowa Code chapter 709 and sections 726.2 and 710.2 in which there is a plea of guilty, verdict of guilty, or special verdict upon which a judgment of conviction is rendered, restitution may be ordered from the offender to the crime victim assistance program for the cost paid by the department for a sexual abuse examination rendered to the victim of that crime pursuant to Iowa Code section 910.2.

61—9.86(915) Erroneous or fraudulent payment—penalty. If a payment or overpayment of a reparation is made because of clerical error, mistaken identity, innocent misrepresentation by or on behalf of the recipient, or other circumstances of a similar nature, not induced by fraud by or on behalf of the recipients, the recipient is liable for repayment of the reparation. However, if the department does not notify the recipient of the erroneous payment or overpayment within one year of the date of payment, the recipient is not responsible for repayment to the department.

If a payment or overpayment has been induced by fraud by or on behalf of a recipient, the recipient is liable for repayment to the department.

61—9.87(915) Right to appeal. An eligible claimant who disagrees with the department’s decision concerning payment or amount of payment has the right to request reconsideration of that decision by the crime victim assistance board. The request for reconsideration must be received by the department within 60 days after the decision of the department is mailed.

Rules 9.80(915) to 9.87(915) are intended to implement Iowa Code section 915.41.

[Filed 12/28/84, Notice 8/29/84—published 1/16/85, effective 4/3/85]
[Filed emergency 7/10/87—published 7/29/87, effective 7/10/87]
[Filed emergency 6/9/89—published 6/28/89, effective 6/9/89]
[Filed emergency 9/1/89—published 9/20/89, effective 9/1/89]
[Filed 10/27/89, Notice 8/23/89—published 11/15/89, effective 12/20/89]
[Filed 12/22/89, Notice 9/20/89—published 1/10/90, effective 2/14/90]
[Filed emergency 5/11/90 after Notice 11/15/89—published 5/30/90, effective 5/11/90]
[Filed emergency 7/20/90—published 8/8/90, effective 7/20/90]
[Filed 5/8/92, Notice 11/27/91—published 5/27/92, effective 7/1/92]
[Filed 10/9/92, Notice 7/8/92—published 10/28/92, effective 12/2/92]
[Filed 2/10/95, Notice 11/23/94—published 3/1/95, effective 4/5/95]
[Filed 4/7/95, Notice 1/18/95—published 4/26/95, effective 5/31/95]
[Filed 12/8/00, Notice 11/1/00—published 12/27/00, effective 1/31/01]
[Filed 5/4/04, Notice 1/21/04—published 5/26/04, effective 6/30/04]
[Filed 12/30/04, Notice 10/13/04—published 1/19/05, effective 2/23/05]

[Filed ARC 4571C (Notice ARC 4350C, IAB 3/27/19), IAB 7/31/19, effective 9/4/19]

◊ Two or more ARCs
1 History transferred from 641—Chapter 8, IAC Supplement 8/8/90
Effective date of 61—9.50(13) to 9.65(13) delayed 70 days by the Administrative Rules Review Committee at its meeting held March 13, 1995; delay lifted by this Committee 4/10/95.
INSURANCE DIVISION[191]

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

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CHAPTER 59
PHARMACY BENEFITS MANAGERS

191—59.1(510B,510C) Purpose. The purpose of this chapter is to administer the provisions of Iowa Code chapters 510, 510B and 510C (2019 Iowa Acts, Senate File 563) relating to the regulation of pharmacy benefits managers.

[ARC 1466C, IAB 5/28/14, effective 7/2/14; ARC 4578C, IAB 7/31/19, effective 9/4/19]

191—59.2(510B) Definitions. The terms defined in Iowa Code sections 510.11 and 510B.1 shall have the same meaning for the purposes of this chapter. The definitions contained in 191—Chapter 58, “Third-Party Administrators,” and 191—Chapter 78, “Uniform Prescription Drug Information Card,” of the Iowa Administrative Code are incorporated by reference. As used in this chapter:

“Complaint” means a written communication from a pharmacy to a pharmacy benefits manager that makes an inquiry or expresses a grievance and includes, but is not limited to, the following:

1. A comment on, contest or appeal by a pharmacy, as permitted by Iowa Code section 510B.8(3) and rule 191—59.5(510B), of a pharmacy benefits manager’s maximum reimbursement amount rate or maximum reimbursement amount list.
2. Any pharmacy’s appeal or request for an independent third-party review of an audit report pursuant to subrules 59.4(4) and 59.4(5).
3. Any request by a pharmacy for an independent third-party review of a termination or suspension decision pursuant to paragraph 59.6(3)“d.”
4. Any inquiries from the commissioner pursuant to subrule 59.8(3).

“Day” means a calendar day, unless otherwise defined or limited.

“Maximum reimbursement amount,” as defined in Iowa Code section 510B.1(6), includes but is not limited to any prices used by a pharmacy benefits manager for therapeutically, pharmaceutically equivalent multiple-source prescription drugs such as maximum allowable cost, federal upper limit pricing, generic effective rate pricing, or any other pricing strategies used by the pharmacy benefits manager.

“Paid” means the later of either the day on which the payment is mailed by the pharmacy benefits manager or the day on which the electronic payment is processed by the pharmacy benefits manager’s bank.

“Pharmacy,” except as used in paragraph 59.4(1)”b.” means “pharmacy” as defined in Iowa Code section 155A.3 and includes “pharmacist,” as defined in Iowa Code section 155A.3, and a pharmacy services administrative organization while acting in its role as a representative of a pharmacist or pharmacy. For purposes of this definition, “pharmacy services administrative organization” means an entity that provides contracting services on behalf of pharmacies with payers and with pharmacy benefits managers, consolidated reimbursement services for pharmacies, and other business support for pharmacies.

[ARC 1466C, IAB 5/28/14, effective 7/2/14; ARC 2518C, IAB 4/27/16, effective 6/1/16]

191—59.3(510B) Timely payment of pharmacy claims.

59.3(1) All benefits payable under a pharmacy benefits management plan shall be paid as soon as feasible but within 20 days after receipt of a clean claim when the claim is submitted electronically and shall be paid within 30 days after receipt of a clean claim when the claim is submitted in paper format.

59.3(2) Payments to the pharmacy for clean claims are considered to be overdue and not timely if not paid within 20 or 30 days, whichever is applicable. If any clean claim is not timely paid, the pharmacy benefits manager must pay the pharmacy interest at the rate of 10 percent per annum commencing the day after any claim payment or portion thereof was due until the claim is finally settled or adjudicated in full.

59.3(3) Pharmacy benefits managers may demonstrate the date a claim is paid by a mail record or a bank statement.

59.3(4) For purposes of this rule, “clean claim” means a claim which is received by any pharmacy benefits manager for adjudication and which requires no further information, adjustment or alteration.
by the pharmacy or the covered individual in order to be processed and paid by the pharmacy benefits manager. A claim is a clean claim if it has no defect or impropriety, including any lack of substantiating documentation, or no particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this chapter. A clean claim includes a resubmitted claim with previously identified deficiencies corrected.

[ARC 1466C; IAB 5/28/14, effective 7/2/14; ARC 2510C, IAB 4/27/16, effective 6/1/16]

191—59.4(510B) Audits of pharmacies by pharmacy benefits managers.

59.4(1) An audit of pharmacy records by a pharmacy benefits manager shall be conducted in accordance with the following:

a. The pharmacy benefits manager conducting the initial on-site audit must provide the pharmacy written notice at least one week prior to conducting any audit;

b. Any audit which involves clinical or professional judgment must be conducted by or in consultation with a pharmacist as defined in Iowa Code section 155A.3;

c. When a pharmacy benefits manager alleges an error in reimbursement has been made to a pharmacy, the pharmacy benefits manager shall provide the pharmacy sufficient documentation to determine the specific claims included in the alleged error;

d. A pharmacy may use the records of a hospital, physician or other authorized practitioner of the healing arts for prescription drugs or medicinal supplies, written or transmitted by any means of communication, for purposes of validating the pharmacy record with respect to orders or refills of a drug dispensed pursuant to a prescription;

e. Each pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies audited by the pharmacy benefits manager;

f. The period covered by an audit may not exceed two years from the date on which the claim was submitted to or adjudicated by a managed care company, insurance company, third-party payor, or any pharmacy benefits manager that represents such entities;

g. Unless otherwise consented to by the pharmacy, an audit may not be initiated or scheduled during the first seven calendar days of any month due to the high volume of prescriptions filled during that time;

h. The preliminary audit report must be delivered to the pharmacy within 120 days after conclusion of the audit. A final written audit report shall be received by the pharmacy within six months of the preliminary audit report or final appeal, whichever is later;

i. A pharmacy shall be allowed at least 30 days following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during an audit; and

j. If it is determined by the pharmacy benefits manager that an error in reimbursement to a pharmacy occurred, the following criteria apply:

1. For each contract between the pharmacy benefits manager and the pharmacy existing on or after January 1, 2015, a pharmacy’s usual and customary price for compounded medications is considered the reimbursable cost, unless the contract between the pharmacy benefits manager and the pharmacy specifically provides details for a pricing methodology for compounded medications.

2. A finding of error in reimbursement must be based on the actual error in reimbursement and not be based on a projection of the number of patients served having a similar diagnosis or on a projection of the number of similar orders or refills for similar prescription drugs.

3. Calculations of errors in reimbursement must not include dispensing fees unless: prescriptions were not actually dispensed, the prescriber denied authorizations, the prescriptions dispensed were medication errors by the pharmacy, or the amounts of the dispensing fees were incorrect.

4. Any clerical or record-keeping error of the pharmacy, including but not limited to a typographical error, scrivener’s error, or computer error, regarding a required document or record shall not be considered fraud by the pharmacy under paragraph 59.6(3) “a” or under a pharmacy’s contract with the pharmacy benefits manager.

5. In the case of an error that has no actual financial harm to the patient or covered entity, the pharmacy benefits manager shall not assess a charge against the pharmacy.
(6) If a pharmacy has entered into a corrective action plan with a pharmacy benefits manager, and if the pharmacy fails to comply with the corrective action plan in a manner that results in overpayments being made by the pharmacy benefits manager to the pharmacy, the pharmacy benefits manager may recover the overpaid amounts. For purposes of this paragraph, “corrective action plan” means an agreement entered into by a pharmacy benefits manager and a pharmacy which is intended to promote accurate submission and payment of pharmacy claims.

(7) During the audit period, interest on any outstanding balance shall not accrue for the pharmacy benefits manager or the pharmacy. For purposes of this rule, the audit period begins with the notice of the audit and ends with a final determination of the audit report.

59.4(2) Notwithstanding any other provision in this rule, the entity conducting the audit shall not use the accounting practice of extrapolation in calculating the recoupment or contractual penalties for audits unless required by state or federal laws or regulations. The entity may not use the accounting practice of extrapolation in a manner more stringent than that required by state or federal laws or regulations.

59.4(3) Recoupment of any disputed funds shall occur only after final disposition of the audit, including the appeals process as set forth in subrules 59.4(4) and 59.4(5).

59.4(4) Each pharmacy benefits manager conducting an audit shall establish an appeals process under which a pharmacy may appeal an unfavorable preliminary audit report to the pharmacy benefits manager. The pharmacy benefits manager shall conduct a review of the unfavorable preliminary audit report. The cost of the audit review shall be paid by the pharmacy benefits manager. If, following the review, the pharmacy benefits manager finds that an unfavorable audit report or any portion thereof is unsubstantiated, the pharmacy benefits manager shall dismiss the unsubstantiated audit report or unsubstantiated portion of the audit report without the necessity of any further proceedings.

59.4(5) A pharmacy benefits manager shall establish a process for an independent third-party review of final audit findings. If, following the appeal of an audit report and upon conducting an audit review, the pharmacy benefits manager finds that an unfavorable audit report or any portion thereof is found to be substantiated, the pharmacy benefits manager shall notify the pharmacy in writing of its right to request an independent third-party review of the final audit findings and the process used to request such a review. If a pharmacy requests an independent third-party review of the final audit findings and the audit report is found to be substantiated, the cost of the third-party review shall be paid by the pharmacy. If a pharmacy requests an independent third-party review of the final audit findings and the audit report is found to be unsubstantiated, the cost of the third-party review shall be paid by the pharmacy benefits manager. If the reviewer finds partially in favor of both parties, the reviewer shall apportion the costs accordingly and each party will bear a portion of the costs of the review.

59.4(6) Rescinded IAB 4/27/16, effective 6/1/16.

59.4(7) Each pharmacy benefits manager conducting an audit shall, after completion of any review process, provide a copy of the final audit report to the covered entity.

59.4(8) This rule shall not apply to any investigative audit which involves fraud, willful misrepresentation, abuse, or any other statutory provision which authorizes investigations relating to but not limited to insurance fraud.

[ARC 1466C, IAB 5/28/14, effective 7/2/14; ARC 2518C, IAB 4/27/16, effective 6/1/16]

191—59.5(510B) Disclosure of national compendia used.

59.5(1) Pursuant to Iowa Code section 510B.8(3), in each contract between a pharmacy benefits manager and a pharmacy beginning or renewed on or after July 1, 2016, a pharmacy benefits manager shall identify how and where pharmacies may find the names of the national compendia or other services the pharmacy benefits manager has used to obtain the pricing data incorporated in the calculation of the maximum reimbursement amounts for therapeutically, pharmaceutically equivalent multiple-source prescription drugs included in the list made available to pharmacies pursuant to rule 191—59.7(510B).

59.5(2) Pursuant to Iowa Code section 510B.8(3), a pharmacy benefits manager shall provide a process, reasonable in procedures and timing to both the pharmacy and the pharmacy benefits manager, to
allow a pharmacy to comment on, contest or appeal a maximum reimbursement amount rate or maximum reimbursement amount list.
[ARC 2518C, IAB 4/27/16, effective 6/1/16]

191—59.6(510B) Termination or suspension of contracts with pharmacies by pharmacy benefits managers.

59.6(1) A contract between a pharmacy benefits manager and a pharmacy shall include a provision describing notification procedures for contract termination. The contract shall require no less than 60 days’ prior written notice by either party that wishes to terminate the contract.

59.6(2) Termination of a contract between a pharmacy benefits manager and a pharmacy or termination of a pharmacy from the network of the pharmacy benefits manager shall not release the pharmacy benefits manager from the obligation to make payments due to the pharmacy for contract-covered services rendered before the contract of the pharmacy was terminated.

59.6(3) The following apply to terminations or suspensions of contracts with pharmacies by pharmacy benefits managers:

a. If the pharmacy benefits manager has evidence that the pharmacy has engaged in fraudulent conduct or poses a significant risk to patient care or safety, the pharmacy benefits manager may immediately suspend the pharmacy from further performance under the contract only if written notice of the suspension and reasoning therefor is provided to the pharmacy, the covered entity and the commissioner.

b. A pharmacy benefits manager shall neither take action, nor imply or state that it may or will take action, to decrease reimbursement or to terminate, suspend, cancel or limit a pharmacy’s participation in a pharmacy benefits manager’s provider network solely or mainly because the pharmacy files a complaint, as defined in rule 191—59.2(510B), with any entity.

c. A pharmacy shall not be terminated from the network or suspended by a pharmacy benefits manager due to any disagreement with a decision of the pharmacy benefits manager to deny or limit benefits to covered individuals or due to any assistance provided to covered individuals by the pharmacy in obtaining reconsideration of a decision of the pharmacy benefits manager.

d. The pharmacy may request an independent third-party review of the final decision to terminate or suspend the contract between the pharmacy benefits manager and the pharmacy by filing with the pharmacy benefits manager a written request for an independent third-party review of the decision. This written request must be filed with the pharmacy benefits manager within 30 days of receipt of the final termination or suspension decision.

e. If a pharmacy requests an independent third-party review of a termination or suspension decision and the termination is found to be substantiated, the cost of the third-party review shall be paid by the pharmacy. If a pharmacy requests an independent third-party review of a termination or suspension decision and the termination is found to be unsubstantiated, the cost of the third-party review shall be paid by the pharmacy benefits manager.

[ARC 1466C, IAB 5/28/14, effective 7/2/14; ARC 2518C, IAB 4/27/16, effective 6/1/16]

191—59.7(510B) Price change. For purposes of Iowa Code section 510B.7(3), a “price increase notification by a manufacturer or supplier” includes price changes made by national compendia or other services used by a pharmacy benefits manager which take into account, in whole or in part, price changes made by manufacturers or suppliers to help facilitate the development of a drug’s maximum reimbursement amount to a pharmacy. A pharmacy benefits manager may comply with the requirements of Iowa Code section 510B.7(3) by keeping a list of current therapeutically, pharmaceutically equivalent multiple-source prescription drugs and current maximum reimbursement amounts for those therapeutically, pharmaceutically equivalent multiple-source prescription drugs and by updating that list at least every three business days with any maximum reimbursement amount changes. This list shall be made available to pharmacies through a readily accessible and easily usable online format, or in some other readily accessible and easily usable format.

[ARC 1466C, IAB 5/28/14, effective 7/2/14; ARC 2518C, IAB 4/27/16, effective 6/1/16]
191—59.8(510B) Complaints.

59.8(1) System to record complaints. Each pharmacy benefits manager shall develop an internal system to record and report complaints. This system shall include but not be limited to the following information regarding each complaint:
   a. The reason for the complaint and any factual documentation submitted by the complainant to support the complaint;
   b. Contact name, address and telephone number of the pharmacy;
   c. Prescription number;
   d. Prescription reimbursement amount for any disputed claim;
   e. Any disputed prescription claim payment date;
   f. Covered entity benefits certificate;
   g. The final determination and outcome of the complaint;
   h. The name of any pharmacy services administrative organization, if known by the pharmacy benefits manager, with which the pharmacy or the pharmacy benefits manager has a contract and that is involved in the matter of the complaint; and
   i. For complaints related to a maximum reimbursement amount, documentation demonstrating compliance with subrule 59.5(1) and rule 191—59.7(510B).

59.8(2) Quarterly complaint summary. A summary of all complaints received by the pharmacy benefits manager each calendar quarter shall be submitted to the commissioner within 30 days after the calendar quarter has ended. The summary shall include the following:
   a. Name, address, telephone number and e-mail address for a contact person for the pharmacy benefits manager;
   b. Information related to any pharmacy’s appeal or request for an independent third-party review of an audit report pursuant to subrules 59.4(4) and 59.4(5);
   c. Information related to any pharmacy’s comment on or contest appeal of a maximum reimbursement rate or maximum reimbursement amount list pursuant to subrule 59.5(2);
   d. Information related to any request by a pharmacy for and the outcome of an independent third-party review of a termination or suspension decision pursuant to paragraph 59.6(3)“d’;
   e. A summary of the information listed in paragraph 59.8(1)”a,” excluding documentation; and
   f. The information listed in paragraphs 59.8(1)”b,” “d,” “e,” and “g.”

59.8(3) Confidentiality. The quarterly complaint summary shall be confidential pursuant to subrule 59.10(5).

59.8(4) Inquiries and complaints from the commissioner.
   a. Pharmacy benefits managers shall comply with Iowa Code section 507B.4A(1) in responding promptly to inquiries from the commissioner, including complaints.
   b. When responding to inquiries and complaints from the commissioner, pharmacy benefits managers shall include the Food and Drug Administration National Drug Code number, the names of the manufacturers of the prescription drugs that are related to the inquiry, and the names of any pharmaceutical wholesalers, if:
      (1) The pharmacy benefits managers can determine that information from their records and other knowledge of the subject matter of the inquiry or complaint; or
      (2) The commissioner has provided enough information in the inquiry or complaint for the pharmacy benefits manager to identify such facts.

[ARC 1466C, IAB 5/28/14, effective 7/2/14; ARC 2518C, IAB 4/27/16, effective 6/1/16]

191—59.9(510,510B) Duty to notify commissioner of fraud. A covered entity that contracts with a pharmacy benefits manager to perform the covered entity’s fraud prevention activities shall require the pharmacy benefits manager to follow Iowa Code section 507E.6 in notifying the commissioner of any detection of fraud, including but not limited to prescription drug diversion activity. “Prescription drug diversion activity,” for purposes of this rule, means the diversion of prescription drugs from legal and medically necessary uses to uses that are illegal and not medically authorized or necessary. A pharmacy benefits manager
shall follow the fraud detection protocol developed by the covered entity or shall allow the covered entity to review and agree to the pharmacy benefits manager’s protocol.

[ARC 1466C, IAB 5/28/14, effective 7/2/14; ARC 2518C, IAB 4/27/16, effective 6/1/16]

191—59.10(507,510,510B) Commissioner examinations of pharmacy benefits managers.

59.10(1) Cooperation of pharmacy benefits managers with the commissioner. Pharmacy benefits managers shall cooperate with the commissioner and comply with the commissioner’s requests to aid with the commissioner’s administration of Iowa Code chapters 507, 507B, 510, and 510B and this chapter, including cooperation and compliance with the commissioner in conducting examinations of pharmacy benefits managers pursuant to Iowa Code chapter 507, and cooperation with the commissioner in conducting investigations pursuant to Iowa Code chapter 507B.

59.10(2) Maintenance of records. Pharmacy benefits managers shall maintain for five years the records necessary to demonstrate to the commissioner compliance with this chapter. Pharmacy benefits managers shall provide the commissioner easy accessibility to records for examination, audit and inspection to verify compliance with this chapter.

59.10(3) Disclosure of payments received by the pharmacy benefits manager.

a. The commissioner may request, and a pharmacy benefits manager shall disclose to the commissioner, the amount of all payments received by the pharmacy benefits manager, and the nature, type, and amounts of all other revenues that the pharmacy benefits manager receives.

b. For purposes of this subrule, “payments received by the pharmacy benefits manager” means the aggregate amount of the following types of payments:

(1) A remuneration collected by the pharmacy benefits manager which is allocated to a covered entity;
(2) An administrative fee collected from the manufacturer in consideration of an administrative service provided by the pharmacy benefits manager to the manufacturer;
(3) A pharmacy network fee; and
(4) Any other fee or amount collected by the pharmacy benefits manager from a manufacturer or labeler for a drug switch program, a formulary management program, a mail service pharmacy, educational support, data sales related to a covered individual, or any other administrative function.

59.10(4) Disclosure of pricing methodology for maximum reimbursement amount.

a. The commissioner may require, and a pharmacy benefits manager shall submit to the commissioner, pursuant to Iowa Code section 510B.8, information related to the pharmacy benefits manager’s pricing methodology for maximum reimbursement amounts.

b. “Disclosure,” as used in Iowa Code section 510B.8(2), means the disclosure to the commissioner of the information the commissioner requires the pharmacy benefits manager to submit pursuant to Iowa Code section 510B.8(1).

c. Iowa Code section 510B.8(2) “a” permits pharmacy benefits managers to establish maximum reimbursement amounts, as defined in Iowa Code section 510B.1(6), for all multiple-source prescription drugs prescribed after the expiration of any generic exclusivity period. Any pricing methodology used by a pharmacy benefits manager for determining the maximum reimbursement amounts for multiple-source prescription drugs including but not limited to those prescribed after the expiration of any generic exclusivity period shall be disclosed to the commissioner, if the commissioner requires pursuant to Iowa Code sections 510B.8(1) and 510B.8(2).

d. Iowa Code section 510B.8(2) “b” permits pharmacy benefits managers to establish maximum reimbursement amounts, as defined in Iowa Code section 510B.1(6), for prescription drugs including, but not limited to, those with at least two or more A-rated therapeutically equivalent, multiple-source prescription drugs with a significant cost difference. Any pricing methodology used by a pharmacy benefits manager for determining the maximum reimbursement amounts for prescription drugs, including but not limited to those with at least two or more A-rated therapeutically equivalent, multiple-source prescription drugs with a significant cost difference, shall be disclosed to the commissioner, if the commissioner requires pursuant to Iowa Code sections 510B.8(1) and 510B.8(2).
e. A pharmacy benefits manager using data sources for determining maximum reimbursement amounts must comply with this paragraph “e.”

(1) The pricing methodology for maximum reimbursement amounts that pharmacy benefits managers shall disclose to the commissioner, if the commissioner requires pursuant to Iowa Code sections 510B.8(1) and 510B.8(2), shall, pursuant to Iowa Code section 510B.8(2) “a” and “b,” determine maximum reimbursement amounts by using comparable prescription drug prices that are:

1. Obtained from multiple nationally recognized comprehensive data sources including, for example, the U.S. Center for Medicare and Medicaid Services’ national average drug acquisition cost, pharmaceutical wholesalers, prescription drug vendors, and pharmaceutical manufacturers for prescription drugs;
2. Nationally available; and
3. Available for purchase by multiple pharmacies in the state of Iowa.

(2) The sources listed in this paragraph and in Iowa Code section 510B.8(2) “c” as sources included among nationally recognized comprehensive data sources are examples of data sources that may be used by pharmacy benefits managers but are not the exclusive data sources that may be used and, if used, that must be disclosed when required by the commissioner.

59.10(5) Confidentiality. Information provided by a pharmacy benefits manager to the commissioner under this rule or under rule 191—59.8(510B) shall be deemed confidential under Iowa Code sections 22.7(2), 22.7(3), 22.7(6), 505.8(8), 505.8(9), 507.14, and 510B.3, as applicable.

59.11(1) Definitions. In addition to the definitions set forth in rule 191—59.2(510B), the definitions of Iowa Code section 510C.1 (2019 Iowa Acts, Senate File 563, section 1) shall apply to this rule.

59.11(2) Filing of annual report. In addition to submitting the third-party administrator annual report required under rule 191—58.11(510), each pharmacy benefits manager shall submit to the commissioner on or before February 15 of each year the annual report required by Iowa Code section 510C.2 (2019 Iowa Acts, Senate File 563, section 2) (PBM annual report). The pharmacy benefits manager shall follow the instructions and use the online submission form provided on the Iowa insurance division’s website (iid.iowa.gov) to file the PBM annual report.

59.11(3) Verification. At least two officers of the pharmacy benefits manager shall certify in writing that they verified the accuracy of the PBM annual report.

59.11(4) Electronic filing. Each pharmacy benefits manager shall submit the PBM annual report electronically as set forth in the instructions, unless otherwise specifically authorized by the commissioner.

59.11(5) Public access. The commissioner shall publish on the Iowa insurance division’s website (iid.iowa.gov) the nonconfidential information received in the PBM annual report.

59.11(6) Completeness of PBM annual report. All information required by the commissioner must be submitted before the PBM annual report shall be considered complete.

59.11(7) Penalties. A pharmacy benefits manager that fails to timely submit to the commissioner a complete PBM annual report shall pay a late fee of $100. If a pharmacy benefits manager fails to submit a complete PBM annual report by May 15, the pharmacy benefits manager shall be subject to penalties as set forth in rule 191—59.12(505,507,507B,510,510B,510C,514L).

191—59.12(505,507,507B,510,510B,510C,514L) Failure to comply. Failure to comply with the provisions of this chapter or with Iowa Code chapters 510, 510B and 510C (2019 Iowa Acts, Senate File 563), or failure to comply with 191—Chapters 58 and 78 or Iowa Code chapters 507 and 514L as they are relevant to the administration of this chapter or of Iowa Code chapters 510, 510B and 510C.
(2019 Iowa Acts, Senate File 563), shall subject the pharmacy benefits manager to the penalties of Iowa Code chapter 507B.

[ARC 1466C, IAB 5/28/14, effective 7/2/14; ARC 2518C, IAB 4/27/16, effective 6/1/16; ARC 4578C, IAB 7/31/19, effective 9/4/19]

These rules are intended to implement Iowa Code chapters 17A, 505, 507, 507B, 510, 510B, 510C (2019 Iowa Acts, Senate File 563) and 514L.

[Filed 7/25/08, Notice 5/7/08—published 8/13/08, effective 9/17/08]*
[Editorial change: IAC Supplement 9/24/08]
[Editorial change: IAC Supplement 11/5/08]

[Filed ARC 1466C (Notice ARC 1412C, IAB 4/2/14), IAB 5/28/14, effective 7/2/14]
[Filed ARC 2518C (Notice ARC 2433C, IAB 3/2/16), IAB 4/27/16, effective 6/1/16]
[Filed ARC 4578C (Notice ARC 4482C, IAB 6/5/19), IAB 7/31/19, effective 9/4/19]

*The September 17, 2008, effective date of subrules 59.6(3), 59.6(5) and 59.7(6) was delayed for 70 days by the Administrative Rules Review Committee at its meeting held September 9, 2008. At its meeting held October 14, 2008, the Committee voted to lift the delay, effective October 15, 2008.
441—40.1 to 40.20 Reserved.

441—40.21(239B) Definitions.

“Applicant” means a person for whom assistance is being requested, parent(s) living in the home with the child(ren), and the nonparental relative as defined in 441—subrule 41.22(3) who is requesting assistance for the child(ren).

“Assistance unit” includes any person whose income is considered when determining eligibility or the family investment program grant amount.

“Casino, gambling casino, or gaming establishment” means an establishment with a primary purpose of accommodating the wagering of money. It does not include:

1. A grocery store which sells groceries including staple foods and which also offers, or is located within the same building or complex as, casino, gambling, or gaming activities; or
2. Any other establishment that offers casino, gambling, or gaming activities incidental to the principal purpose of the business.

An automated teller machine (ATM) or a point-of-sale (POS) terminal located within those areas of an establishment where individuals are banned due to age restrictions associated with gambling, established by state or federal law or by any other regulatory entity having the authority to do so, is considered to be in a casino, gambling casino, or gaming establishment.

“Central office” shall mean the state administrative office of the department of human services.

“Change in income” means a permanent change in hours worked or rate of pay, any change in the amount of unearned income, or the beginning or ending of any income.

“Department” shall mean the Iowa department of human services.

“Dependent” means an individual who can be claimed by another individual as a dependent for federal income tax purposes.

“Dependent child” or “dependent children” means a child or children who meet the nonfinancial eligibility requirements of the family investment program.

“Electronic benefit transfer transaction” means the use of a credit or debit card service, automated teller machine, point-of-sale terminal, or access to an online system for the withdrawal of funds or the processing of a payment for merchandise or a service.

“Income in kind” is any gain or benefit which is not in the form of money payable directly to the eligible group including nonmonetary or in-kind benefits, such as meals, clothing, and vendor payments. Vendor payments are money payments which are paid to a third party and not to the eligible group.

“Initial two months” means the first two consecutive months for which assistance is paid. This may include a month for which a partial payment is made.

“Liquor store” means any retail establishment which sells exclusively or primarily intoxicating liquor or other alcoholic beverages. Such term does not include a grocery store which sells both intoxicating liquor and groceries including staple foods (within the meaning of Section 3(r) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(r))).
Unless exempt as described in this definition, a retail establishment meets the definition of a liquor store when it has a North American Industry Classification System (NAICS) number that categorizes the retail establishment as either a beer, wine and liquor store or as a drinking place (alcoholic beverages). A retail establishment that does not have either type of NAICS code is considered to exclusively or primarily sell intoxicating liquor when 95 percent or more of the retail establishment’s gross sales are from intoxicating liquor and it is not a United States Department of Agriculture-certified Supplemental Nutrition Assistance Program (SNAP) retailer.

Whenever “medical institution” is used in this title, it shall mean a facility which is organized to provide medical care, including nursing and convalescent care, in accordance with accepted standards as authorized by state law and as evidenced by the facility’s license. A medical institution may be public or private. Medical institutions include the following:

1. Hospitals
2. Extended care facilities (skilled nursing)
3. Intermediate care facilities
4. Mental health institutions
5. Hospital schools

“Needy specified relative” means a nonparental specified relative, listed in 441—subrule 41.22(3), who meets all the eligibility requirements to be included in the family investment program.

“Parent” means a legally recognized parent, including an adoptive parent, or a biological father if there is no legally recognized father.

“Payment month” means the calendar month for which assistance is paid.

“Payment standard” means the total needs of a group as determined by adding need according to the schedule of basic needs, described in 441—subrule 41.28(2), to any allowable special needs, described in 441—subrule 41.28(3).

“Promoting independence and self-sufficiency through employment, job opportunities, and basic skills (PROMISE JOBS) program” means the department’s work and training program as described in 441—Chapter 93.

“Prospective budgeting” means the determination of eligibility and the amount of assistance for a calendar month based on the best estimate of income and circumstances which will exist in that calendar month.

“Qualified alien” means an alien:

1. Who is lawfully admitted for permanent residence in the United States under the Immigration and Nationality Act (INA);
2. Who is granted asylum in the United States under Section 208 of the INA;
3. Who is a refugee admitted to the United States under Section 207 of the INA;
4. Who is paroled into the United States under Section 212(d)(5) of the INA for a period of at least one year;
5. Whose deportation from the United States is withheld under Section 243(h) of the INA as in effect before April 1, 1997, or under Section 241(b)(3) of the INA as amended to December 20, 2010;
6. Who is granted conditional entry to the United States pursuant to Section 203(a)(7) of the INA as in effect before April 1, 1980;
7. Who is admitted to the United States as an Amerasian as described in 8 U.S.C. Section 1612(b)(2)(A)(ii)(V);
8. Who is a Cuban/Haitian entrant to the United States as described in 8 U.S.C. Section 1641(b)(7);
9. Who is a battered alien as described in 8 U.S.C. Section 1641(c); or
10. Who is certified as a victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 20, 2010.

“Qualifying quarters” means all of the qualifying quarters of coverage as defined under Title II of the Social Security Act that were worked by a parent of an alien while the alien was under the age of 18 and all of the qualifying quarters that were worked by a spouse of the alien during their marriage if the alien remains married to the spouse or the spouse is deceased. No qualifying quarter of coverage that is creditable under Title II of the Social Security Act for any period beginning after December 31, 1996,
may be credited to an alien if the parent or spouse of the alien received any federal means-tested public benefit during the period for which the qualifying quarter is so credited.

“Recipient” means a person for whom assistance is paid, parent(s) living in the home with the eligible child(ren) and nonparental relative as defined in 441—subrule 41.22(3) who is receiving assistance for the child(ren). Unless otherwise specified, a person is not a recipient for any month in which the assistance issued for that person is subject to recoupment because the person was ineligible.

“Retail establishment which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment” means an establishment that includes live entertainment at locations such as, but not limited to, strip clubs and gentleman’s clubs. It also includes stores and theaters that exclusively or primarily sell or feature adult-oriented videos and movies such as, but not limited to, adult book stores and adult movie theaters. A retail establishment meets this definition when the department has confirmed the primary nature of the business through the description on the business’s website, phone contact with the establishment, a site visit, or other means such as common local knowledge.

“Standard of need” means the total needs of a group as determined by adding need according to the schedule of living costs, described in 441—subrule 41.28(2), to any allowable special needs, described in 441—subrule 41.28(3).

“Stepparent” means a person who is not the parent of the dependent child, but is the legal spouse of the dependent child’s parent, by ceremonial or common-law marriage.

“Unborn child” shall include an unborn child during the entire term of the pregnancy.

This rule is intended to implement Iowa Code sections 239B.3, 239B.5, and 239B.6.

[ARC 9439B, IAB 4/6/11, effective 6/1/11; ARC 2812C, IAB 11/9/16, effective 1/1/17]

441—40.22(239B) Application. The application for the family investment program shall be submitted on the Financial Support Application, Form 470-0462 or Form 470-0462(S). The application shall be signed by the applicant, the applicant’s authorized representative or, when the applicant is incompetent or incapacitated, someone acting responsibly on the applicant’s behalf. When both parents, or a parent and a stepparent, are in the home and eligibility is determined on a family or household basis, one parent or stepparent may sign the application and attest to the information for the assistance unit.

40.22(1) Each individual wishing to do so shall have the opportunity to apply for assistance without delay. When the parent is in the home with the child and is not prevented from acting as payee by reason of physical or mental impairment, this parent shall make the application.

40.22(2) An applicant may be assisted by other individuals in the application process; the client may be accompanied by such individuals in contact with the department, and when so accompanied, may also be represented by them. When the applicant has a guardian, the guardian shall participate in the application process.

40.22(3) The applicant shall immediately be given an application form to complete. When the applicant requests that the form be mailed, the department shall send the necessary forms in the next outgoing mail.

40.22(4) A new application is not required when adding a new person to the eligible group or when a parent or a stepparent becomes a member of the household.

40.22(5) Reinstatement.

a. Assistance shall be reinstated without a new application when all necessary information is provided before the effective date of cancellation and eligibility can be reestablished, or the family meets the conditions described at 441—subparagraph 41.30(3)“f”(9). EXCEPTION: The reinstatement provisions of subrule 40.22(5) do not apply when assistance is canceled due to the imposition of a subsequent limited benefit plan as described at 441—subrule 41.24(8), unless the limited benefit plan is stopped as described in 441—paragraph 41.24(8)“g” or “h.”

b. When assistance has been canceled for failure to provide requested information, assistance shall be reinstated without a new application if all information necessary to establish eligibility, including verification of any changes, is provided within 14 days of the effective date of cancellation and eligibility can be reestablished. If the fourteenth calendar day falls on a weekend or state holiday, the client shall
have until the next business day to provide the information. The effective date of assistance shall be the
date all information required to establish eligibility is provided.

c. When assistance has been canceled for failure to return a completed review form pursuant
to subrule 40.27(3), assistance shall be reinstated without a new application if the completed form is
received by the department within 14 days of the effective date of cancellation and eligibility can be
reestablished. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have
until the next business day to provide the information. The effective date of assistance shall be the date
the Review/Recertification Eligibility Document is received.

d. When assistance has been canceled for failure to complete a required review interview,
assistance shall be reinstated without a new application if the interview is completed and all necessary
information to determine eligibility, including verification of any changes, is provided within 14 days of
the effective date of cancellation and eligibility is reestablished. If the fourteenth calendar day falls on
a weekend or state holiday, the client shall have until the next business day to provide the information.
The effective date of assistance shall be the date the interview is completed.

This rule is intended to implement Iowa Code sections 239B.3, 239B.5 and 239B.6.

[ARC 8500B, IAB 2/10/10, effective 3/1/10; ARC 1478C, IAB 6/11/14, effective 8/1/14]

441—40.23(239B) Date of application. The date of application is the date an identifiable Financial
Support Application, Form 470-0462 or Form 470-0462(S), is received by the department. When an
application is delivered to a closed office, it will be considered received on the first day that is not a
weekend or state holiday following the day that the office was last open.

40.23(1) The date of application is also the date an identifiable application is received by a designated
worker who is in any disproportionate share hospital, federally qualified health center or other facility in
which outstationing activities are provided. The hospital, health center or other facility will forward the
application to the department office that is responsible for the completion of the eligibility determination.

40.23(2) An identifiable application is an application containing a legible name and address that has
been signed.

40.23(3) A new application is not required when adding a person to an existing eligible group.
This person is considered to be included in the application that established the existing eligible group.
However, in these instances, the date of application to add a person is the date the change is reported.
When it is reported that a person is anticipated to enter the home, the date of application to add the person
shall be the date of the report.

a. In those instances where a person previously excluded from the eligible group as described at
441—subrule 41.27(11) is to be added to the eligible group, the date of application to add the person is
the date the person indicated willingness to cooperate.

b. EXCEPTIONS:

(1) When adding a person who was previously excluded from the eligible group for failing to comply with 441—subrule 41.22(13), the date of application to add the person is the date the social
security number or proof of application for a social security number is provided.

(2) When adding a person who was previously excluded from the eligible group as described at
441—subrule 41.23(5) or 41.25(5) or rule 441—46.29(239B), the date of application to add the person
is the first day after the period of ineligibility has ended.

(3) When adding a person who was previously excluded from the eligible group as described at
441—subrule 41.24(8), the date of application to add the person is the date the person signs a family
investment agreement.

40.23(4) Grace period.

a. When an application has been denied for failure to provide requested information, if all
necessary information to establish eligibility, including verification of any changes, is provided within
14 days of the date of denial, a new application is not required. If the fourteenth calendar day falls on a
weekend or state holiday, the applicant shall have until the next business day to provide the information.
If eligibility can be established, the effective date of assistance is the date all of the information is
provided.
b. When an application has been denied for failure to attend an interview, if the interview is completed and all necessary information to establish eligibility, including verification of any changes, is provided within 14 days of the date of denial, a new application is not required. If the fourteenth calendar day falls on a weekend or state holiday, the applicant shall have until the next business day to provide the information. If eligibility can be established, the effective date of assistance is the date the interview is completed or the date all of the information is provided, whichever is later.

This rule is intended to implement Iowa Code section 239B.2.

[ARC 8500B, IAB 2/10/10, effective 3/1/10; ARC 1478C, IAB 6/11/14, effective 8/1/14]

441—40.24(239B) Procedure with application.

40.24(1) The decision with respect to eligibility shall be based primarily on information furnished by the applicant.

a. The applicant shall report no later than at the time of the interview any change as defined at 40.27(4) “e” that occurs after the application was signed. Any change that occurs after the interview shall be reported by the applicant within five days from the date the change occurred.

b. The department shall notify the applicant in writing of additional information or verification that is required to establish eligibility for assistance. Failure of the applicant to supply the information or verification requested or to request assistance and authorize the department to secure the requested information or verification from other sources shall serve as a basis for denial of assistance. Signing a general authorization for release of information to the department does not meet this responsibility.

(1) Five working days shall be considered as a reasonable period for the applicant to supply the required information or verification. The department shall extend the deadline when the applicant requests an extension because the applicant is making every effort to supply the information or verification but is unable to do so.

(2) “Supply” shall mean the requested information is received by the department by the specified due date. Any time taken beyond the required time frame shall be considered a delay on the part of the applicant.

c. When an individual is added to an existing eligible group, the five-day requirement for reporting changes shall be waived. These individuals and eligible groups shall be subject to the recipient’s ten-day reporting requirement as defined in 40.27(4).

40.24(2) The department or the designated worker as described in subrule 40.23(1) shall conduct a face-to-face or telephone interview with the applicant before approval of the application for assistance.

a. The worker shall assist the applicant, when requested, in providing information needed to determine eligibility and the amount of assistance.

b. The application process shall include a visit, or visits, to the home of the child and the person with whom the child will live during the time assistance is granted under the following circumstances:

(1) When it is the judgment of the worker or the supervisor that a home visit is required to clarify or verify information pertaining to the eligibility requirements; or

(2) When the applicant requests a home visit for the purpose of completing a pending application.

c. When adding an individual to an existing eligible group, the interview requirement may be waived.

40.24(3) Rescinded IAB 1/14/09, effective 2/1/09.

40.24(4) The decision with respect to eligibility shall be based on the applicant’s eligibility or ineligibility on the date the department enters all eligibility information into the department’s computer system, except as described in subrule 40.24(3). The applicant shall become a recipient on the date all eligibility information is entered into the department’s computer system and the computer system determines the applicant is eligible for aid.

This rule is intended to implement Iowa Code sections 239B.3, 239B.5 and 239B.6.

[ARC 7740B, IAB 5/6/09, effective 6/10/09; ARC 8500B, IAB 2/10/10, effective 3/1/10]

441—40.25(239B) Time limit for decision. A determination of approval or denial shall be made as soon as possible, but no later than 30 days following the date of filing an application. A written notice of decision shall be issued to the applicant the next working day following a determination of eligibility.
or ineligibility. This time standard shall apply except in unusual circumstances, such as when the department and the applicant have made every reasonable effort to secure necessary information which has not been supplied by the date the time limit expired; or because of emergency situations, such as fire, flood or other conditions beyond the administrative control of the department. When eligibility is dependent upon the birth of a child, the time limit may be extended while awaiting the birth of the child. When it becomes evident that due to an error on the part of the department, eligibility will not be established within the 30-day limit, the application shall be approved pending a determination of eligibility.

This rule is intended to implement Iowa Code sections 239B.3, 239B.4, 239B.5 and 239B.6.

441—40.26(239B) Effective date of grant. New approvals shall be effective as of the date the applicant becomes eligible for assistance, but in no case shall the effective date be earlier than seven days following the date of application. When an individual is added to an existing eligible group, the individual shall be added effective as of the date the individual becomes eligible for assistance, but in no case shall the effective date be earlier than seven days following the date the change is reported. When it is reported that a person is anticipated to enter the home, the effective date of assistance shall be no earlier than the date of entry or seven days following the date of report, whichever is later.

When the change is timely reported as described at subrule 40.27(4), a payment adjustment shall be made when indicated. When the individual’s presence is not timely reported as described at subrule 40.27(4), excess assistance issued is subject to recovery.

In those instances where a person previously excluded from the eligible group as described at 441—subrule 41.27(11) is to be added to the eligible group, the effective date of eligibility shall be seven days following the date the person indicated willingness to cooperate. However, in no instance shall the person be added until cooperation has actually occurred.

Exceptions: When adding a person who was previously excluded from the eligible group for failing to comply with 441—subrule 41.22(13), the effective date of eligibility shall be seven days following the date that the social security number or proof of application for a social security number is provided.

When adding a person who was previously excluded from the eligible group as described at 441—subrules 41.23(5), 41.25(5) and 46.28(2) and rule 441—46.29(239B), the effective date of eligibility shall be seven days following the date that the period of ineligibility ended.

When adding a person who was previously excluded from the eligible group as described at 441—subrule 41.24(8), the effective date of eligibility shall be seven days following the date the person signs a family investment agreement. In no case shall the effective date be within the six-month ineligibility period of a subsequent limited benefit plan as described at 441—paragraph 41.24(8)“a.”

This rule is intended to implement Iowa Code section 239B.3.

441—40.27(239B) Continuing eligibility.

40.27(1) Eligibility factors shall be reviewed at least every six months for the family investment program. An interview may be conducted at the time of a review.

40.27(2) A redetermination of specific eligibility factors shall be made when:

a. The recipient reports a change in circumstances (for example, a change in income, as defined at rule 441—40.21(239B)), or

b. A change in the recipient’s circumstances comes to the attention of a staff member.

40.27(3) Information for semiannual reviews shall be submitted on Form 470-2881, 470-2881(M), 470-2881(S), or 470-2881(EMS), Review/Recertification Eligibility Document (RRED).

a. The department shall supply the review form to the recipient as needed or upon request. The department shall pay the cost of postage to return the form.

(1) When the review form is issued in the department’s regular end-of-month mailing, the recipient shall return the completed form to the department by the fifth calendar day of the following month.

(2) When the review form is not issued in the department’s regular end-of-month mailing, the recipient shall return the completed form to the department by the seventh day after the date it is mailed by the department.
eligibility correct shall the applicant’s accordance department. by original eligibility IAC persons recipient. written recipient department (2) insofar persons recipient. The department. The recipient shall cooperate by giving complete and accurate information needed to establish eligibility and the amount of the family investment program grant. b. The recipient shall complete the required review form when requested by the department in accordance with subrule 40.27(3). Failure to return a completed form shall result in cancellation of assistance. A completed form is a form with all items answered, signed, dated and accompanied by verification as required in 441—paragraphs 41.27(1)“i” and 41.27(2)“h.” c. The recipient has the primary responsibility for providing information and verification needed to establish eligibility and the amount of the family investment program grant. The recipient shall supply, insofar as the recipient is able, information and verification needed within ten working days from the date a written request is mailed by the department to the recipient’s current mailing address or given to the recipient. The department shall extend the deadline when the recipient requests an extension because the recipient is making every effort to supply the information or verification but is unable to do so.

(1) “Supply” shall mean that the requested information or verification is received by the department by the specified due date.

(2) When the recipient is unable to furnish information or verification needed to establish eligibility and the amount of the family investment program grant, the recipient shall request assistance from the department.

(3) Failure to supply the information or verification requested or to request assistance and authorize the department to secure the requested information or verification from other sources shall serve as a basis for cancellation of assistance. Signing a general authorization for release of information to the department does not meet this responsibility.

d. The recipient or applicant shall cooperate with the department when the recipient’s or applicant’s case is selected by quality control for verification of eligibility. The recipient or applicant shall also cooperate with the front end investigations conducted by the department of inspections and appeals to determine whether information supplied to the department by the client is complete and correct regarding pertinent public assistance information unless the investigation revolves solely around the circumstances of a person whose income and resources do not affect family investment program eligibility. (See department of inspections and appeals rules 481—Chapter 72.) Failure to cooperate shall serve as a basis for cancellation or denial of the family’s assistance. Once denied or canceled for failure to cooperate, the family may reapply but shall not be considered for approval until cooperation occurs.

e. The recipient, or an individual being added to the existing eligible group, shall timely report any change in the following circumstances:

(1) Beginning or ending income, including receipt of a nonrecurring lump sum.

(2) Resources.

(3) Members of the household.

(4) School attendance of a child.

(5) Mailing or living address.

(6) Receipt of a social security number.

f. A report shall be considered timely when made within ten days from:

(1) The receipt of resources or income or the date income ended.

(2) The date the address changes.

(3) The date the child is officially dropped from the school rolls.

(4) The date a person enters or leaves the household.
(5) The receipt of a social security number.

  g. When a change is not timely reported, any excess assistance paid shall be subject to recovery.

  40.27(5) After assistance has been approved, eligibility for continuing assistance and the amount of the grant shall be effective as of the first of each month. Any change affecting eligibility or benefits reported during a month shall be effective the first day of the next calendar month except as follows:

  a. When the recipient reports a new person to be added to the eligible group, and that person meets eligibility requirements, a payment adjustment shall be made for the month of report, subject to the effective date of grant limitations prescribed in 441—40.26(239B).

  b. When cancellation of assistance occurs later because issuance of a timely notice, as required by 441—7.7(17A), requires that the action be delayed until the first day of the second calendar month, any overpayment received in the first calendar month shall be recouped.

  c. When the recipient reports a change in income or circumstances timely, as defined in 40.24(1) or 40.27(4), the department shall determine prospective eligibility and the grant amount for the following month based on the change.

  1. A payment adjustment shall be made when indicated.

  2. Recoupment shall be made for any overpayment, with one exception. When a change in income is timely reported by a recipient and timely acted upon by the department, but the timely notice, as required by 441—7.7(17A), requires the action be delayed until the second calendar month following the month of change, and eligibility continues, recoupment shall not be made.

  d. When an individual included in the eligible group becomes ineligible, that individual’s needs shall be removed prospectively effective the first day of the next calendar month. When the action must be delayed due to administrative requirements, a payment adjustment or recoupment shall be made when appropriate.

  e. When a sanction under 441—paragraph 41.22(6) “f” is implemented, the change shall be effective:

  1. The first day of the next calendar month after the change has occurred when the income maintenance unit determines noncooperation; or

  2. After the income maintenance unit receives notification from the child support recovery unit when the child support recovery unit determines noncooperation.

  f. When a sanction under 441—paragraph 41.22(6) “f” is removed, the change shall be effective the first day of the next calendar month after the recipient has expressed willingness to cooperate, as described in 441—paragraph 41.22(6) “f.” However, action to remove the sanction shall be delayed until:

  1. Cooperation has actually occurred; or

  2. The income maintenance unit has received notification from the child support recovery unit that the client has cooperated.

  g. A different effective date shall be applied when specifically indicated in family investment program rules, such as in 441—subrule 41.25(5) and 441—subparagraph 41.27(9) “c” (2).

This rule is intended to implement Iowa Code sections 239B.2, 239B.3, 239B.5, 239B.6 and 239B.18.

[ARC 7740B, IAB 5/6/09, effective 6/10/09; ARC 8500B, IAB 2/10/10, effective 3/1/10; ARC 0148C, IAB 6/13/12, effective 8/1/12; ARC 1478C, IAB 6/11/14, effective 8/1/14]

441—40.28(239B) Referral for investigation. The department may refer questionable cases to the department of inspections and appeals for further investigation.

This rule is intended to implement Iowa Code section 239B.5.

[ARC 4573C, IAB 7/31/19, effective 9/4/19]

441—40.29(239B) Conversion to the X-PERT system. Rescinded IAB 10/4/00, effective 12/1/00.

These rules are intended to implement Iowa Code chapter 239B.

[Filed June 23, 1955; amended August 30, 1972, June 3, 1975, June 27, 1975]
[Filed 9/29/76, Notice 8/23/76—published 10/20/76, effective 11/24/76]  
[Filed 8/18/77, Notice 6/15/77—published 9/7/77, effective 10/12/77]  
[Filed 8/9/78, Notice 6/28/78—published 9/6/78, effective 11/1/78]

[Filed 12/14/78, Notice 9/7/79—published 11/8/79, effective 1/1/80]
[Filed 10/24/79, Notice 8/22/79—published 11/14/79, effective 1/1/80]
[Filed emergency 6/30/80—published 7/23/80, effective 7/1/80]
[Filed 12/19/80, Notice 10/29/80—published 1/7/81, effective 2/11/81]
[Filed without Notice 3/24/81—published 4/15/81, effective 6/1/81]
[Filed emergency 6/30/81—published 7/22/81, effective 7/1/81]
[Filed 6/30/81, Notice 4/29/81—published 7/22/81, effective 9/1/81]
[Filed emergency 9/25/81—published 10/14/81, effective 10/1/81]
[Filed emergency 10/23/81—published 11/11/81, effective 11/1/81]
[Filed 6/15/82, Notice 3/17/82—published 7/7/82, effective 9/1/82]
[Filed emergency 7/1/82—published 7/21/82, effective 7/1/82]
[Filed 7/1/82, Notice 4/28/82—published 7/21/82, effective 9/1/82]
[Filed 9/1/83, Notice 6/22/83—published 9/28/83, effective 11/2/83]
[Filed emergency 12/16/83—published 1/4/84, effective 1/1/84]
[Filed 12/16/83, Notice 11/9/83—published 1/4/84, effective 2/8/84]
[Filed 5/4/84, Notice 2/29/84—published 5/23/84, effective 7/1/84]
[Filed emergency 9/28/84—published 10/24/84, effective 10/1/84]
[Filed without Notice 9/28/84—published 10/24/84, effective 12/1/84]
[Filed 9/28/84, Notice 8/15/84—published 10/24/84, effective 12/1/84]
[Filed 12/11/84, Notice 10/10/84—published 1/2/85, effective 3/1/85]
[Filed emergency 1/21/85—published 2/13/85, effective 2/1/85]
[Filed 3/22/85, Notice 2/13/85—published 4/10/85, effective 6/1/85]
[Filed 4/29/85, Notice 10/24/84—published 5/22/85, effective 7/1/85]
[Filed 7/26/85, Notice 6/5/85—published 8/14/85, effective 10/1/85]
[Filed 11/15/85, Notice 10/9/85—published 12/4/85, effective 2/1/86]
[Filed emergency 5/28/86 after Notice 4/9/86—published 6/18/86, effective 6/1/86]
[Filed emergency 7/25/86 after Notice 6/4/86—published 8/13/86, effective 8/1/86]
[Filed 9/3/86, Notice 7/2/86—published 9/24/86, effective 11/1/86]
[Filed 10/17/86, Notice 8/27/86—published 11/5/86, effective 1/1/87]
[Filed 11/14/86, Notice 10/8/86—published 12/3/86, effective 2/1/87]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed 9/24/87, Notice 8/12/87—published 10/21/87, effective 12/1/87]
[Filed emergency 6/29/89 after Notice 5/3/89—published 7/26/89, effective 7/1/89]
[Filed 12/15/89, Notice 7/26/89—published 1/10/90, effective 3/1/90]
[Filed 4/13/90, Notice 3/7/90—published 5/2/90, effective 7/1/90]
[Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]
[Filed without Notice 9/18/91—published 10/16/91, effective 11/21/91]
[Filed emergency 10/10/91—published 10/30/91, effective 11/21/91]
[Filed 1/16/92, Notice 9/18/91—published 2/5/92, effective 4/1/92]
[Filed 1/29/92, Notice 10/16/91—published 2/19/92, effective 3/25/92]
[Filed emergency 6/11/92 after Notice 4/15/92—published 7/8/92, effective 7/1/92]
[Filed 7/17/92, Notice 6/10/92—published 8/5/92, effective 10/1/92]
[Filed emergency 9/17/93—published 10/13/93, effective 10/1/93]
[Filed 12/16/93, Notice 10/13/93—published 1/5/94, effective 3/1/94]
[Filed 2/16/95, Notice 11/23/94—published 3/15/95, effective 5/1/95]
[Filed 8/15/96, Notice 5/8/96—published 9/11/96, effective 11/1/96]
[Filed emergency 1/15/97—published 2/12/97, effective 3/1/97]
[Filed 4/11/97, Notice 2/12/97—published 5/7/97, effective 7/1/97]
[Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]
[Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 3/1/98]
[Filed emergency 1/14/98 after Notice 11/19/97—published 2/11/98, effective 2/1/98]
[Filed 6/10/98, Notice 5/6/98—published 7/1/98, effective 9/1/98]
[Filed 3/10/99, Notice 11/18/98—published 4/7/99, effective 5/31/99]
[Filed 5/10/00, Notice 3/22/00—published 5/31/00, effective 8/1/00]
[Filed 9/12/00, Notice 7/12/00—published 10/4/00, effective 12/1/00]
[Filed 10/11/00, Notice 8/23/00—published 11/1/00, effective 1/1/01]
[Filed 6/13/01, Notice 4/18/01—published 6/30/01, effective 9/1/01]
[Filed emergency 9/12/02 after Notice 7/24/02—published 10/2/02, effective 10/1/02]
[Filed emergency 6/14/04—published 7/7/04, effective 7/1/04]
[Filed 7/1/04, Notice 1/21/04—published 7/21/04, effective 9/1/04]
[Filed 9/23/04, Notice 7/7/04—published 10/13/04, effective 11/17/04]
[Filed emergency 11/16/05—published 12/7/05, effective 12/1/05]
[Filed 10/20/06, Notice 8/30/06—published 11/8/06, effective 11/1/07]
[Filed emergency 10/14/08 after Notice 8/27/08—published 11/5/08, effective 11/1/08]
[Filed emergency 12/11/08 after Notice 10/8/08—published 1/14/09, effective 2/1/09]
[Filed 12/15/08, Notice 10/22/08—published 1/14/09, effective 3/1/09]
[Filed ARC 7740B (Notice ARC 7590B, IAB 2/25/09), IAB 5/6/09, effective 6/10/09]
[Filed Emergency After Notice ARC 8500B (Notice ARC 8272B, IAB 11/4/09), IAB 2/10/10, effective 3/1/10]
[Filed ARC 9439B (Notice ARC 9309B, IAB 12/29/10), IAB 4/6/11, effective 6/1/11]
[Filed ARC 0148C (Notice ARC 0048C, IAB 3/21/12), IAB 6/13/12, effective 8/1/12]
[Filed ARC 1478C (Notice ARC 1385C, IAB 3/19/14), IAB 6/11/14, effective 8/1/14]
[Filed ARC 2812C (Notice ARC 2684C, IAB 8/17/16), IAB 11/9/16, effective 1/1/17]
[Filed ARC 4573C (Notice ARC 4439C, IAB 5/22/19), IAB 7/31/19, effective 9/4/19]
TITLE VII
FOOD PROGRAMS

CHAPTER 65
FOOD ASSISTANCE PROGRAM ADMINISTRATION

PREAMBLE

The basis for the food assistance program is as provided in Title 7 of the Code of Federal Regulations. The purpose of this chapter is to provide for adoption of new and amended federal regulations as they are published, to establish a legal basis for Iowa’s choice of administrative options when administrative options are given to the state in federal regulations, to implement the policy changes that the United States Department of Agriculture (USDA) directs states to implement that are required by law but are not yet included in federal regulations, and to implement USDA-approved demonstration projects and waivers of federal regulations.

DIVISION I

441—65.1(234) Definitions.

“Department” means the Iowa department of human services.

“Food assistance” means benefits provided by the federal program administered through Title 7, Chapter II of the Code of Federal Regulations, Parts 270 through 283.

“Notice of expiration” means either a message printed on an application for continued program participation, Review/Recertification Eligibility Document (RRED), Form 470-2881, which is automatically issued to the household, or a hand-issued Form 470-0325, Notice of Expiration.

“Parent” means natural, legal, or stepmother or stepfather.

“Sibling” means biological, legal, step-, half-, or adoptive brother or sister.

441—65.2(234) Application.

65.2(1) Application filing. Persons in need of food assistance benefits may file an application at any local department office in Iowa or over the Internet.

a. An application is filed the day a local department office receives an application for food assistance benefits that contains the applicant’s name and address and is signed by either a responsible member of the household or the household’s authorized representative. The application may be filed on:
   (1) Form 470-0306 or 470-0307 (Spanish), Application for Food Assistance;
   (2) Form 470-0462 or Form 470-0466 (Spanish), Health and Financial Support Application; or
   (3) Form 470-4080 or 470-4080(S), Electronic Food Assistance Application.

b. When an application is delivered to a closed office, it will be considered received on the first day that is not a weekend or state holiday following the day that the office was last open. An electronic application is considered received on the first department workday following the date the department office received the application.

c. A household shall complete a Health and Financial Support Application when any person in the household is applying for or receiving aid through the family investment program, family medical assistance program (FMAP)-related Medicaid, or the refugee resettlement assistance programs.

d. The application is complete when a completed application form is submitted.

e. Households receiving food assistance benefits in Iowa may apply for continued participation by submitting Form 470-2881, Review/Recertification Eligibility Document.

65.2(2) Failure to provide verification. When a household files an initial application and the department requests additional verification, the applicant shall have ten days to provide the requested verification. If the applicant fails to provide the verification within ten days, the department may deny the application immediately. If the applicant provides the department with the requested verification prior to the thirtieth day from the date of application, the department shall reopen the case and provide benefits from the date of application. If the household provides the verification in the second 30 days
after the date of the application, the department shall reopen the case and provide benefits from the date
the verification was provided.

441—65.3(234) Administration of program. The food assistance program shall be administered in
accordance with the Food and Nutrition Act of 2008, 7 U.S.C. 2001 et seq., and in accordance with
federal regulations, Title 7, Parts 270 through 283 as amended to June 19, 2006. A copy of the federal
law and regulations may be obtained at no more than the actual cost of reproduction by contacting the
Division of Financial, Health, and Work Supports, Department of Human Services, Hoover State Office
Building, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, (515)281-3133.

441—65.4(234) Issuance. The department shall issue food assistance benefits by electronic benefits
transfer (EBT) cards.

65.4(1) Schedule. Benefits for ongoing certifications shall be made available to households on a
staggered basis during the first ten calendar days of each month.

65.4(2) EBT cards. EBT cards shall be mailed to recipients except in the event of a disaster. In the
event of a disaster, disaster EBT cards will be distributed through the local office.

[ARC 8500B, IAB 2/10/10, effective 3/1/10; ARC 4573C, IAB 7/31/19, effective 9/4/19]

441—65.5(234) Simplified reporting.

65.5(1) Identification. All households are subject to simplified reporting requirements.

65.5(2) Determination of eligibility and benefits. Eligibility and benefits for simplified reporting
households shall be determined on the basis of the household’s prospective income and circumstances.

65.5(3) Certification periods. Households shall be certified as follows:

a. Households that have no earned income and in which all adult members are elderly or disabled
shall be assigned certification periods of 12 months.

b. All other households shall be assigned certification periods of six months.

c. Exceptions:

(1) A household that has unstable circumstances or that includes an able-bodied adult without
dependents shall be assigned a shorter certification period consistent with the household’s circumstances,
but generally no less than three months.

(2) A shorter certification period may be assigned at application or recertification to match the food
assistance recertification date to the family investment program or medical assistance annual review date.

65.5(4) Reporting responsibilities. Simplified reporting households are required to report changes
as follows:

a. The household shall report if the household’s total gross income exceeds 130 percent of the
federal poverty level for the household size. The household must report this change within ten days
of the end of the month in which the income exceeds this level. A categorically eligible household that
reports income over 130 percent of the federal poverty level and that remains eligible for benefits shall
not be required to make any additional report of changes.

b. A household containing an able-bodied adult without dependents shall report any change in
work hours that brings that adult below 20 hours of work per week, averaged monthly. The household
must report this change within ten days of the end of the month in which the change in work hours occurs.

65.5(5) Verification submitted with report form. Rescinded IAB 9/10/08, effective 10/1/08.

65.5(6) Additional information and verification. Rescinded IAB 9/10/08, effective 10/1/08.

65.5(7) Action on reported changes. The department shall act on all reported changes for households
regardless of the household’s reporting requirements.

65.5(8) Entering or leaving simplified reporting. Rescinded IAB 9/10/08, effective 10/1/08.

65.5(9) Reinstatement. Rescinded IAB 9/10/08, effective 10/1/08.

441—65.6(234) Delays in certification.

65.6(1) When by the thirtieth day after the date of application the agency cannot take any further
action on the application due to the fault of the household, the agency shall give the household an
additional 30 days to take the required action. The agency shall send the household a notice of pending status on the thirtieth day.

65.6(2) When there is a delay beyond 60 days from the date of application and the agency is at fault and the application is complete enough to determine eligibility, the application shall be processed. For subsequent months of certification, the agency may require a new application form to be completed when household circumstance indicates changes have occurred or will occur.

65.6(3) When there is a delay beyond 60 days from the date of application and the agency is at fault and the application is not complete enough to determine eligibility, the application shall be denied. The household shall be notified to file a new application and that it may be entitled to retroactive benefits.

441—65.7(234) Expedited service. Rescinded IAB 5/2/01, effective 6/1/01.

441—65.8(234) Deductions.

65.8(1) Standard allowance for households with heating or air-conditioning expenses. When a household is receiving heating or air-conditioning service for which it is required to pay all or part of the expense or receives assistance under the Low-Income Home Energy Assistance Act (LIHEAA) of 1981, the heating or air-conditioning standard shall be allowed.

a. The standard allowance for utilities which include heating or air-conditioning costs shall change annually effective each October 1 using a methodology approved by the Food and Nutrition Service of the United States Department of Agriculture.

b. Effective October 1, 2013, five dollars will be subtracted from this amount to allow for cost neutrality necessary for the standard medical expense deduction.

65.8(2) Heating expense. Heating expense is the cost of fuel for the primary heating service normally used by the household.

65.8(3) Telephone standard. When a household is receiving a Standard utility allowance under subrule 65.8(1) or 65.8(5) or is solely responsible for telephone expenses, a standard allowance shall be allowed. This allowance shall change annually effective each October 1 using a methodology approved by the Food and Nutrition Service of the United States Department of Agriculture.

65.8(4) Energy assistance payments. For purposes of prorating the low income energy assistance payments to determine if households have incurred out-of-pocket expenses for utilities, the heating period shall consist of the months from October through March.

65.8(5) Standard allowance for households without heating or air-conditioning expenses. When a household is receiving some utility service other than heating or air-conditioning for which it is responsible to pay all or part of the expense, the nonheating or air-conditioning standard shall be allowed. These utility expenses cannot be solely for telephone.

a. This allowance shall change annually effective each October 1 using a methodology approved by the Food and Nutrition Service of the United States Department of Agriculture.

b. Effective October 1, 2013, five dollars will be subtracted from this amount to allow for cost neutrality necessary for the standard medical expense deduction.

65.8(6) Excluded payments. A utility expense which is reimbursed or paid by an excluded payment, including HUD or FmHA utility reimbursements, shall not be deductible.

65.8(7) Excess medical expense deduction. Notwithstanding anything to the contrary in these rules or regulations, at certification, households having a member eligible for the excess medical expense deduction shall be allowed to provide verification of expenses so that a reasonable projection of the member’s medical expenses anticipated to occur during the household’s certification period can be made. The household may choose to claim actual expenses or to use the standard medical expense deduction.

a. Actual medical expense.

   (1) The projection may be based on available information about the member’s medical condition, public or private medical insurance coverage, and current verified medical expenses.

   (2) Households that choose to claim actual medical expenses shall not be required to report changes in medical expenses that were anticipated to occur during the certification period.

b. Standard medical expense.
(1) A household may choose a standard medical expense deduction of $105 if the household incurs more than $35 per month in medical expenses.

(2) A household that chooses the standard deduction shall not be required to report changes in medical expenses during the certification period.
   c. Rescinded IAB 8/1/07, effective 10/1/07.
546.8(8) Child support payment deduction. Rescinded IAB 5/2/01, effective 6/1/01.
546.8(9) Standard deduction. Each household will receive a standard deduction from income equal to
   8.31 percent of the net income limit for food assistance eligibility. No household will receive an amount
   less than $144 or more than 8.31 percent of the net income limit for a household of six members. The
   amount of the standard deduction is adjusted for inflation annually as directed by the Food and Nutrition
   Service of the U.S. Department of Agriculture.
546.8(10) Sharing utility standards. Rescinded IAB 9/4/02, effective 10/1/02.
546.8(11) Excess shelter cap. Rescinded IAB 5/2/01, effective 6/1/01.

This rule is intended to implement Iowa Code section 234.12.
[ARC 8992B, IAB 8/11/10, effective 10/1/10; ARC 1148C, IAB 10/30/13, effective 1/1/14]

441—65.9(234) Treatment centers and group living arrangements. Alcohol or drug treatment or
   rehabilitation centers and group living arrangements shall complete Form 470-2724, Monthly Facility
   Report, on a monthly basis and return the form to the local department office where the center is assigned.

441—65.10(234) Reporting changes. Rescinded IAB 9/10/08, effective 10/1/08.

441—65.11(234) Discrimination complaint. Individuals who feel that they have been subject to
discrimination may file a written complaint with the Diversity Programs Unit, Department of Human
   Services, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

441—65.12(234) Appeals. Fair hearings and appeals are provided according to the department’s rules,
441—Chapter 7.

441—65.13(234) Joint processing.
   65.13(1) Joint processing with SSI. The department will handle joint processing of supplemental
   security income and food assistance applications by having the social security administration complete
   and forward food assistance applications.
   65.13(2) Joint processing with public assistance. The department shall jointly process public
   assistance and food assistance applications.
   65.13(3) Single interview for assistance. In joint processing of public assistance and food assistance
   applications, the department shall conduct a single interview at initial application for both purposes.

441—65.14(234) Rescinded, effective 10/1/83.

441—65.15(234) Proration of benefits. Benefits shall be prorated using a 30-day month.
This rule is intended to implement Iowa Code section 234.12.

441—65.16(234) Complaint system. Clients wishing to file a formal written complaint concerning the
   food assistance program may submit Form 470-0323, or 470–0323(S), Food Assistance Complaint, to
   the office of field support. Department staff shall encourage clients to use the form.
   [ARC 8500B, IAB 2/10/10, effective 3/1/10]

441—65.17(234) Involvement in a strike. An individual is not involved in a strike at the individual’s
   place of employment when the individual is not picketing and does not intend to picket during the course
   of the dispute, does not draw strike pay, and provides a signed statement that the individual is willing and
   ready to return to work but does not want to cross the picket line solely because of the risk of personal
   injury or death or trauma from harassment. The service area manager shall determine whether such a
   risk to the individual’s physical or emotional well-being exists.
441—65.18(234) Rescinded, effective 8/1/86.

441—65.19(234) Monthly reporting/retrospective budgeting. Rescinded IAB 9/10/08, effective 10/1/08.

441—65.20(234) Notice of expiration issuance.

65.20(1) Issuance of the automated Notice of Expiration will occur with the mailing of Form 470-2881, 470-2881(M), 470-2881(S), or 470-2881(MS), Review/Recertification Eligibility Document (RRED), or a hand-issued Form 470-0325, Notice of Expiration.

65.20(2) Issuance of the Notice of Expiration, Form 470-0325, will occur at the time of certification if the household is certified for one month, or for two months, and will not receive the automated Notice of Expiration.

[ARC 8500B, IAB 2/10/10, effective 3/1/10]

441—65.21(234) Claims.

65.21(1) Time period. Inadvertent household error claims shall be calculated back to the month the error originally occurred to a maximum of three years before the month of discovery of the overissuance. Agency error claims shall be calculated back to the month the error originally occurred to a maximum of one year before the month of discovery of the overissuance.

65.21(2) Suspension status. Rescinded IAB 7/1/98, effective 8/5/98.

65.21(3) Application of restoration of lost benefits. Rescinded IAB 3/6/02, effective 5/1/02.

65.21(4) Demand letters. Households that have food assistance claims shall return the repayment agreement no later than 20 days after the date the demand letter is mailed.

   a. For agency error and inadvertent household error, when households do not return the repayment agreement by the due date or do not timely request an appeal, allotment reduction shall occur with the first allotment issued after the expiration of the Notice of Adverse Action time period.

   b. For intentional program violation, when households do not return the repayment agreement by the due date, allotment reduction shall occur with the next month’s allotment.

65.21(5) Adjustments for claim repayment. A household or authorized representative may initiate a claim repayment by using benefits in an EBT account. The client or authorized representative shall complete Form 470-2574, EBT Adjustment Request, to authorize adjustments to a household’s EBT account.

65.21(6) Collection of claims. Rescinded IAB 5/30/01, effective 8/1/01.

[ARC 7928B, IAB 7/1/09, effective 9/1/09]

441—65.22(234) Verification.

65.22(1) Required verification.

   a. Income. Households shall be required to verify income at time of application, recertification and when income is reported or when income changes with the following exceptions:

      1. Households are not required to verify the public assistance grant.

      2. Households are not required to verify job insurance benefits when the information is available to the department from the department of employment services.

      3. Households are only required to verify interest income at the time of application and recertification.

   b. Dependent care costs. Rescinded IAB 3/10/10, effective 2/10/10.

   c. Medical expenses. Households shall be required to verify medical expenses at the time of application and whenever a change is reported. For recertification:

      (1) A household that chose to claim actual expenses must verify medical expenses.

      (2) A household that chose the standard medical expense deduction shall be required to declare only if the excess expense still exists.

   d. Shelter costs. Rescinded IAB 3/10/10, effective 2/10/10.

   e. Utilities. Rescinded IAB 3/10/10, effective 2/10/10.

   f. Telephone expense. Rescinded IAB 5/2/01, effective 6/1/01.
Child support payment deduction. Households shall be required to verify legally obligated child support and child medical support payments made to a person outside of the food assistance household only at certification and recertification and whenever the household reports a change.

65.22(2) Failure to verify. When the household does not verify an expense as required, no deduction for that expense will be allowed.

65.22(3) Special verification procedures. Persons whose applications meet the initial criteria for error-prone cases may be subject to special verification procedures, including a second face-to-face interview and additional documentation requirements in accordance with department of inspections and appeals’ rules 481—Chapter 72.

Clients are required to cooperate with the investigation division of the department of inspections and appeals in establishing eligibility factors, including attending requested interviews. Refusal to cooperate will result in denial or cancellation of the household’s food assistance benefits. Once denied or terminated for refusal to cooperate, the household may reapply but shall not be determined eligible until cooperation occurs.

[ARC 856B, IAB 3/10/10, effective 2/10/10]

441—65.23(234) Prospective budgeting.

65.23(1) Weekly or biweekly income. The department shall convert income and deductions that occur on a weekly or biweekly basis to monthly figures using family investment program procedures.

65.23(2) Income averaging. The department shall average income by anticipating income fluctuations over the certification period. The number of months used to arrive at the average income should be the number of months that are representative of the anticipated income fluctuation.

441—65.24(234) Inclusion of foster children in household. Foster children living with foster parents will not be considered to be members of the food assistance household unless the household elects to include the foster children in the household. Foster care payments received for foster children not included in the household will be excluded from the income of the household receiving the payment.

441—65.25(234) Effective date of change. A food assistance change caused by, or related to, a public assistance grant change will have the same effective date as the public assistance change.

441—65.26(234) Eligible students. A student who is enrolled in an institution of higher education shall meet student eligibility criteria if the student:

1. Is employed for an average of 20 hours per week and is paid for this employment; or

2. Is self-employed for an average of 20 hours per week and receives average weekly earnings at least equal to the federal minimum wage multiplied by 20 hours.

441—65.27(234) Voluntary quit or reduction in hours of work.

65.27(1) Applicant households. A member of an applicant household who without good cause voluntarily quits a job or reduces hours of work to less than 30 hours weekly within 30 days before the date the household applies for benefits shall be disqualified from participating in the food assistance program according to the provisions of paragraphs 65.28(12) ‘a’ and ‘b.’

65.27(2) Participating individuals. Participating individuals are subject to the same disqualification periods as provided under subrule 65.28(12) when the participating individuals voluntarily quit employment without good cause or voluntarily reduce hours of work to less than 30 hours per week, beginning with the month following the adverse notice period.

441—65.28(234) Work requirements.

65.28(1) Persons required to register. Each household member who is not exempt by subrule 65.28(2) shall be registered for employment at the time of application, and once every 12 months after initial registration, as a condition of eligibility. Registration is accomplished when the applicant signs an application form that contains a statement that all members in the household who are required to
register for work are willing to register for work. This signature registers all members of that food assistance household that are required to register.

65.28(2) Exemptions from work registration. The following persons are exempt from the work registration requirement:
   a. A person younger than 16 years of age or a person 60 years of age or older. A person aged 16 or 17 who is not a head of a household or who is attending school, or is enrolled in an employment training program on at least a half-time basis is exempt.
   b. A person physically or mentally unfit for employment.
   c. A household member subject to and complying with any work requirement under Title IV of the Social Security Act including mandatory PROMISE JOBS referral.
   d. A parent or other household member who is responsible for the care of a dependent child under age six or an incapacitated person.
   e. A person receiving unemployment compensation.
   f. A regular participant in a drug addiction or alcohol treatment and rehabilitation program which is certified by the Iowa department of public health, division of substance abuse.
   g. A person who is employed or self-employed and working a minimum of 30 hours weekly or receiving weekly earnings at least equal to the federal minimum wage multiplied by 30 hours.
   h. A student enrolled at least half-time in any recognized school, recognized training program, or an institution of higher education (provided that students have met the requirements of federal regulation, Title 7, Part 273.5, as amended to December 31, 1986).

65.28(3) Losing exempt status. Persons who lose exempt status due to any change in circumstances that is subject to the reporting requirements shall register for employment when the change is reported. Persons who lose exempt status due to a change in circumstances that is not subject to the reporting requirements for that household shall register for employment no later than at the household’s next recertification.

65.28(4) Registration process. Upon reaching a determination that an applicant or a member of the applicant’s household is required to register, the pertinent work requirements, the rights and responsibilities of work-registered household members, and the consequences of failure to comply shall be explained to the applicant. A written statement of the above shall be provided to each registrant in the household. The written statement shall also be provided at recertification and when a previously exempt member or a new household member becomes subject to work registration.

Registration for all nonexempt household members required to work register is accomplished when the applicant or recipient signs an application, recertification, or reporting form containing an affirmative response to the question, “Do all members who are required to work register and participate in job search agree to do so?” or similarly worded statement.

65.28(5) Deregistration. Work registrants who obtain employment or otherwise become exempt from the work requirement subsequent to registration or who are no longer certified for participation are no longer considered registered.

65.28(6) Work registrant requirements. Work registrants shall respond to a request from the department or its designee for supplemental information regarding employment status or availability for work.

65.28(7) Employment and training program.
   a. The employment and training program for food assistance recipients is designed to assist:
      (1) Persons who have lost jobs or are underemployed and who need new skills in order to reenter the workplace because there are no jobs available for which the persons are trained.
      (2) Persons who have been out of the workforce for a period of time to regain licensure or certification in an area in which they are already trained.
      (3) Persons who wish to upgrade their employment for better wages and benefits.
   b. The department or its designee shall serve as the provider of employment and training services for food assistance recipients who wish to volunteer, except for those who are also recipients of family investment program (FIP) benefits. Federal law prohibits FIP recipients from participating in any food assistance employment and training program.
c. The program offers a range of services from basic skills to advanced training in order to accommodate persons with various levels of need and abilities. The department or its designee may require a volunteer to engage in vocational testing activities when deemed necessary to determine if a component is appropriate for improving the volunteer’s opportunity for employment.

65.28(8) Employment and training components. Employment and training components include individual job search, job club, educational services, and job retention services. The department or its designee shall offer employment and training components subject to the availability of sufficient funding to cover program costs. Availability of components may vary among the areas where employment and training are offered.

a. Individual job search. The individual job search shall be modeled after the family investment program’s PROMISE JOBS individual job search component, as described at 441—subrule 93.6(2).

b. Job club. The employment and training job club shall be modeled after the family investment program’s PROMISE JOBS job club, as described at 441—subrule 93.6(1).

c. Educational services. Educational services offered shall include general educational development (GED), adult basic education (ABE), English as a second language (ESL), and vocational training or educational opportunities limited to a two-year college degree. Educational services may include, but are not limited to, obtaining continuing education credit hours needed for a recipient to become recertified or to renew licensure for a profession.

d. Job retention services. Job retention services are intended to provide needed assistance with costs associated with beginning employment. Services are available only to persons who have received employment or training services under this subrule. Job retention services will be offered up to 90 days after the person secures employment. Services may include payment of:

(1) A transportation allowance of $50 per month for round-trip travel of 50 miles or less or $100 per month for round-trip travel of 51 miles or more.

(2) The cost of testing, certification, licensing, bonding, or legal services required for employment.

(3) The cost of equipment, tools, uniforms, or other special clothing required by the job.

(4) Other reasonable and necessary costs related to starting and retaining employment.

65.28(9) Exemptions from employment and training programs. Rescinded IAB 5/5/10, effective 4/15/10.

65.28(10) Time spent in an employment and training program. Rescinded IAB 5/5/10, effective 4/15/10.

65.28(11) Supportive services. Program participants shall be provided with services necessary to complete an employment and training component to the extent allowable under federal regulations at 7 CFR 237.7(e)(4) as amended to January 1, 2009, and to the extent there is sufficient funding to cover the costs.

a. The department shall provide participants in employment and training components an allowance for costs of transportation or other costs reasonably necessary and directly related to participation in the components as follows:

(1) A transportation allowance of $50 per month for round-trip travel of 50 miles or less or $100 per month for round-trip travel of 51 miles or more.

(2) Reasonable and necessary costs of attending a specific course of study, such as tuition, books, fees, training manuals, tools, equipment, uniforms and special clothing, safety items, and other items that all students in the course are required to have.

b. The department may authorize the employment and training service provider to reimburse the provider of care directly for the costs of dependent care expenses that the employment and training service provider determines to be necessary for the participation of a person in the components.

(1) Reimbursement for dependent care shall be authorized only to the extent that another source is not available to provide the care at no cost to the employment and training program and shall be based on the child care assistance program reimbursement rates as described at 441—paragraph 170.4(7)“a.”

(2) The caretaker relative of a dependent in a family receiving FIP is not eligible for the dependent care reimbursement.
65.28(12) Failure to comply. This subrule applies only to persons who are mandatory work registrants as required by subrule 65.28(1).
   a. When a person has refused or failed without good cause to comply with the work registration requirements in this rule, that person shall be ineligible to participate in the food assistance program as follows:
      (1) First violation: The later of (1) the date the individual complies with the requirement; or (2) two months.
      (2) Second violation: The later of (1) the date the individual complies with the requirement; or (2) three months.
      (3) Third and subsequent violations: The later of (1) the date the individual complies with the requirement; or (2) six months.
   b. The disqualification period shall begin with the first month following the expiration of the adverse notice period, unless a fair hearing is requested.
65.28(13) Noncompliance with comparable requirements. The department shall treat a mandatory work registrant’s failure to comply with an unemployment compensation requirement that is comparable to a food assistance work registration requirement as a failure to comply with the corresponding food assistance requirement. Disqualification procedures in subrule 65.28(12) shall be followed.
65.28(14) Ending disqualification. Following the end of the disqualification periods for noncompliance and as provided in rules 441—65.27(234) and 441—65.28(234), participation may resume.
   a. An applicant disqualified under subrule 65.27(1) may be approved for benefits after serving the minimum disqualification period and complying with the work requirement, as follows:
      (1) If the applicant voluntarily quit a job, the applicant must obtain a job comparable to the one that the applicant quit.
      (2) If the applicant voluntarily reduced hours of employment to less than 30 hours per week, the applicant must start working 30 or more hours per week.
   b. A disqualified individual who is a member of a currently participating eligible household shall be added to the household after the minimum disqualification period has been served and the person has complied with the failed requirement as follows:
      (1) If the member failed or refused to register for work with the department, the member complies by registering.
      (2) If the member voluntarily quit a job, the member must obtain a job comparable to the one quit.
      (3) If the member voluntarily reduced hours of employment to less than 30 hours per week, the member must start working 30 or more hours per week.
   c. An individual may reestablish eligibility during a disqualification period by becoming exempt from the work requirement as provided in subrule 65.28(2).
65.28(15) Suitable employment. Employment shall be considered unsuitable if:
   a. The wage offered is less than the highest of the applicable federal minimum wage, the applicable state minimum wage, or 80 percent of the federal minimum wage if neither the federal nor state minimum wage is applicable.
   b. The employment offered is on a piece-rate basis and the average hourly yield the employee can reasonably be expected to earn is less than the applicable hourly wages specified in paragraph “a” above.
   c. The household member, as a condition of employment or continuing employment, is required to join, resign from, or refrain from joining a legitimate labor organization.
   d. The work offered is at a site subject to a strike or lockout at the time of the offer unless the strike has been enjoined under Section 208 of the Labor-Management Relations Act (29 U.S.C. 78A) (commonly known as the Taft-Hartley Act), or unless an injunction has been issued under Section 10 of the Railway Labor Act (45 U.S.C. 160).
   e. The household member involved can demonstrate or the department otherwise becomes aware that:
      (1) The degree of risk to health and safety is unreasonable.
(2) The member is physically or mentally unfit to perform the employment, as documented by medical evidence or by reliable information from other sources.

(3) The employment offered within the first 30 days of registration is not in the member’s major field of experience.

(4) The distance from the member’s home to the place of employment is unreasonable considering the expected wage and the time and cost of commuting. Employment shall not be considered suitable if daily commuting time exceeds two hours per day, not including the transporting of a child to and from a child care facility. Employment shall also not be considered suitable if the distance to the place of employment prohibits walking and neither public nor private transportation is available to transport the member to the job site.

(5) The working hours or nature of the employment interferes with the member’s religious observances, convictions, or beliefs.

65.28(16) Applicants for supplemental security income (SSI) and food assistance. Household members who are jointly applying for SSI and for food assistance shall have the requirements for work registration waived until:
   a. They are determined eligible for SSI and thereby become exempt from work registration, or
   b. They are determined ineligible for SSI whereupon a determination of work registration status will be made.

65.28(17) Determining good cause. The department or its designee shall determine whether good cause exists for failure to comply with the work registration, employment and training, and voluntary quit requirements in 441—Chapter 65. In determining whether good cause exists, the facts and circumstances shall be considered, including information submitted by the household member involved and the employer.

Good cause shall include circumstances beyond the member’s control, such as, but not limited to, illness of the registrant or of another household member requiring the presence of the registrant, a household emergency, the unavailability of transportation, or the lack of adequate child care for children who have reached age 6 but are under age 12.

65.28(18) Measuring the three-year period for able-bodied nonexempt adults without dependents. The three-year period as provided for in federal regulations at 7 CFR 273.24 as amended to June 19, 2002, starts on December 1, 2002, and ends November 30, 2005. Subsequent three-year periods start with the month of December following the end of the previous period.

65.28(19) Mini-simplified food assistance program.
   a. Scope. The department operates a mini-simplified food assistance program for households that:
      (1) Also receive benefits under the family investment program; and
      (2) Include a parent who is exempt from food assistance requirements for work registration due to caring for a child under the age of six.
   b. Effect. The mini-simplified food assistance program allows replacement of certain food assistance program work rules with work rules of the Temporary Assistance to Needy Families program. The value of the household’s monthly food assistance benefits shall be combined with the household’s monthly family investment program benefit amount to determine the maximum number of hours the department can require a household member under the family investment program to participate in an unpaid work activity that is subject to the federal Fair Labor Standards Act. Maximum required hours of participation for a month are determined by dividing the total amount of benefits by the state or federal minimum wage, whichever wage is higher.

[ARC 8500B, IAB 2/10/10, effective 3/1/10; ARC 8712B, IAB 5/5/10, effective 4/15/10]

441—65.29(234) Income.

65.29(1) Self-employment income. “Self-employment income” means the net profit from self-employment.
   a. Determination of net profit. “Net profit from self-employment” means gross self-employment income less:
(1) A standard amount of 40 percent, as allowed by the state’s family investment (TANF) program, or

(2) At the household’s request, actual allowable expenses as specified in federal regulations at 7 CFR 273.11 as amended to January 1, 2011.

b. Uneven proration of self-employment income. Once a household with self-employment income is determined eligible, the household has the following options for computation of the benefit level:

(1) Using the same monthly self-employment income amount which was used to determine eligibility, or

(2) Unevenly prorating the household’s annual self-employment income over the period for which the household’s self-employment income was averaged to more closely approximate the time when the income is actually received. If this option is chosen, the self-employment income assigned in any month together with other income and deductions at the time of certification cannot result in the household’s exceeding the maximum monthly net income eligibility standards for the household’s size.

65.29(2) Job insurance benefits. When the department of human services uses information provided by the department of workforce development to verify job insurance benefits, the benefits shall be considered received the second day after the date that the check was mailed. When the second day falls on a Sunday or federal legal holiday, the time shall be extended to the next mail delivery day.

When the client notifies the agency that the amount of job insurance benefits used is incorrect, the client shall be allowed to verify the discrepancy. A benefit adjustment shall be made when indicated. The client must report the discrepancy before the benefit month or within ten days of the date on the Notice of Decision, Form 470-0485, 470-0486, or 470-0486(S), applicable to the benefit month, whichever is later, in order to receive corrected benefits.

65.29(3) Exclusion of income from 2000 census employment. Rescinded IAB 9/4/02, effective 10/1/02.

65.29(4) Interest income. Prorate interest income by dividing the amount anticipated during the certification period by the number of months in the certification period.

65.29(5) Social security plans for achieving self-support (PASS). Notwithstanding anything to the contrary in these rules or regulations, exclude income amounts necessary for fulfillment of a plan for achieving self-support (PASS) under Title XVI of the Social Security Act.

65.29(6) Student income. In determining eligibility, the department shall exclude educational income, including any educational loans on which payment is deferred, grants, scholarships, fellowships, veterans’ educational benefits, and the like excluded under Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

a. Notwithstanding anything to the contrary in these rules or regulations, the department shall exclude educational income based on amounts earmarked by the institution, school, program, or other grantor as made available for the specific costs of tuition, mandatory fees, books, supplies, transportation and miscellaneous personal expenses (other than living expenses).

b. If the institution, school, program, or other grantor does not earmark amounts made available for the allowable costs involved, students shall receive an exclusion from educational income for educational assistance verified by the student as used for the allowable costs involved. Students can also verify the allowable costs involved when amounts earmarked are less than amounts that would be excluded by a strict earmarking policy.

c. For the purpose of this rule, mandatory fees include the rental or purchase of equipment, materials and supplies related to the course of study involved.

65.29(7) Elementary and high school student income. Rescinded IAB 5/2/01, effective 6/1/01.

65.29(8) Vendor payments. Rescinded IAB 5/2/01, effective 6/1/01.

65.29(9) HUD or FmHA utility reimbursement. Rescinded IAB 5/2/01, effective 6/1/01.

65.29(10) Welfare reform and regular household honorarium income. All moneys paid to a food assistance household in connection with the welfare reform demonstration longitudinal study or focus groups shall be exempted.
65.29(11) Income of ineligible aliens. The department shall use all but a pro-rata share of ineligible aliens’ income and deductible expenses to determine eligibility and benefits of any remaining household members.

65.29(12) Unearned income. Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (Federal Insurance Contribution Act, state and federal income taxes). Net unearned income shall be determined by deducting reasonable income-producing costs from the gross unearned income. Money left after this deduction shall be considered gross income available to the household.

[ARC 8500B, IAB 2/10/10, effective 3/1/10; ARC 0148C, IAB 6/13/12, effective 8/1/12]

441—65.30(234) Resources.

65.30(1) Jointly held resources. When property is jointly held it shall be assumed that each person owns an equal share unless the intent of the persons holding the property can be otherwise established.

65.30(2) Resource limit. The resource limit for a household that includes a person aged 60 or over or a disabled person is $3000. The resource limit for other households is $2000. These amounts are adjusted for inflation annually as directed by the Food and Nutrition Service of the U.S. Department of Agriculture.

65.30(3) Resources of SSI and FIP household members. Notwithstanding anything to the contrary in these rules or in federal regulations, all resources of SSI or FIP recipients are excluded. For food assistance purposes, those members’ resources, if identified, cannot be included when a household’s total resources are calculated.

65.30(4) Earned income tax credits. Notwithstanding anything to the contrary in these rules or in federal regulations, earned income tax credits (EITC) shall be excluded from consideration as a resource for 12 months from the date of receipt if:

a. The person receiving the EITC was participating in the food assistance program at the time the credits were received; and

b. The person participated in the program continuously during the 12-month period.

65.30(5) Student income. Exclude from resources any income excluded by subrule 65.29(6).

65.30(6) Motor vehicles. One motor vehicle per household shall be excluded without regard to its value. The value of remaining motor vehicles shall be determined using federal regulations at 7 CFR 273.8, as amended to April 29, 2003.

65.30(7) Retirement accounts. Exclude from resources the value of:

a. Any funds in a plan, contract, or account described in Sections 401(a), 403(a), 403(b), 408, 408A, 457(b), and 501(c)(18) of the Internal Revenue Code of 1986.

b. Any funds in a Federal Thrift Savings Plan account as provided in Section 8439 of Title 5, United States Code.

c. Any retirement program or account included in any successor or similar provision that may be enacted and determined to be exempt from tax under the Internal Revenue Code of 1986.

d. Any other retirement plans, contracts, or accounts determined to be exempt by the Secretary of the U.S. Department of Agriculture.

65.30(8) Education accounts. Exclude from resources the value of:

a. Any funds in a qualified tuition program described in Section 529 of the Internal Revenue Code of 1986 or in a Coverdell Education Savings Account under Section 530 of the Internal Revenue Code.

b. Any other education plans, contracts or accounts determined to be exempt by the Secretary of the U.S. Department of Agriculture.

441—65.31(234) Homeless meal providers. When a local office of the department is notified that an establishment or shelter has applied to be able to accept food assistance benefits for homeless persons, staff shall obtain a written statement from the establishment or shelter. The statement must contain information on how often meals are served by the establishment or shelter, the approximate number of meals served per month, and a statement that the establishment or shelter does serve meals to homeless
persons. This information must be dated and signed by a person in charge of the administration of the establishment or shelter and give the person’s title or function with the establishment.

The establishment or shelter shall cooperate with agency staff in the determination of whether or not meals are served to the homeless.

441—65.32(234) Basis for allotment. The minimum benefit amount for all eligible one-member and two-member households shall be 8 percent of the maximum monthly allotment for a household size of one member.

441—65.33(234) Dependent care deduction. Households shall be allowed a deduction for the amount of monthly dependent care expenses.

[ARC 85568, IAB 3/10/10, effective 2/10/10]

441—65.34(234) Exclusion of advance earned income tax credit payments from income. Rescinded IAB 10/30/91, effective 1/1/92.

441—65.35(234) Migrant and seasonal farm worker households. Rescinded IAB 10/30/91, effective 1/1/92.

441—65.36(234) Electronic benefit transfer (EBT) of food stamp benefits. Rescinded IAB 3/5/03, effective 5/1/03.

441—65.37(234) Eligibility of noncitizens. The following groups of aliens who are lawfully residing in the United States and are otherwise eligible are eligible for food assistance benefits:

   65.37(1) Aliens who are receiving benefits or assistance for blindness or disability as specified in 7 CFR 271.2, as amended to April 6, 1994, regardless of their immigration date.

   65.37(2) Aliens who have been residing in the United States for at least five years as legal permanent residents.

   65.37(3) Aliens who hold one of the following statuses:
   a. A refugee admitted under Section 207 of the Immigration and Nationality Act.
   b. A Cuban or Haitian entrant admitted under Section 501(e) of the Refugee Education Assistance Act of 1980.
   d. An asylee admitted under Section 208 of the Immigration and Nationality Act.
   e. An alien whose deportation or removal has been withheld under Section 243(h) or 2411(b)(3) of the Immigration and Nationality Act.

   65.37(4) Aliens aged 18 or under, regardless of their immigration date. The department shall exclude the income and resources of a sponsor when determining food assistance eligibility and benefits for an alien aged 18 or under.

441—65.38(234) Income deductions. Notwithstanding anything to the contrary in these rules or regulations, student households cannot receive an income deduction for dependent care expenses that were excluded from educational income.

441—65.39(234) Categorical eligibility.

   65.39(1) Notwithstanding anything to the contrary in these rules or in federal regulations, a household in which all members are recipients of a state or local general assistance (GA) program is subject to categorical eligibility provisions of the food assistance program provided that the state or local program:
   a. Has income limits at least as stringent as the food assistance gross income test; and
   b. Gives assistance other than one-time emergency payments that cannot be given for more than one continuous month.
65.39(2) Notwithstanding anything to the contrary in these rules or in federal regulations, a household is subject to categorical eligibility provisions of the food assistance program for any month in which the household is determined eligible for the Iowa promoting healthy marriage program pursuant to rule 441—47.2(234).

[ARC 9173B, IAB 11/3/10, effective 1/1/11]


441—65.41(234) Actions on changes increasing benefits. Action on changes resulting in an increase in benefits will take place after the verification is received.

441—65.42(234) Work transition period. Rescinded IAB 3/6/02, effective 5/1/02.

441—65.43(234) Household composition. Rescinded IAB 5/2/01, effective 6/1/01.

441—65.44(234) Reinstatement.

65.44(1) The department shall reinstate assistance without a new application when the element that caused termination of a case no longer exists and eligibility can be reestablished prior to the effective date of cancellation.

65.44(2) When assistance has been canceled for failure to provide requested information, assistance shall be reinstated without a new application if all information necessary to establish eligibility, including verification of any changes, is provided within 14 days of the effective date of cancellation and eligibility can be reestablished. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information. The effective date of assistance shall be the date all information required to establish eligibility is provided.

[ARC 8500B, IAB 2/10/10, effective 3/1/10]

441—65.45(234) Conversion to the X-PERT system. Rescinded IAB 3/6/02, effective 5/1/02.

441—65.46(234) Disqualifications. Notwithstanding anything to the contrary in these rules, food assistance program violation disqualifications for persons who are not participating in the food assistance program shall be imposed in the same manner as program violation disqualifications are imposed for persons who are participating in the food assistance program.

65.46(1) First and second violations. Notwithstanding anything to the contrary in these rules or regulations, the disqualification penalty for a first intentional program violation shall be one year except for those first violations involving a controlled substance. The disqualification penalty for a second intentional violation and any first violation involving a controlled substance shall be two years.

65.46(2) Conviction on trafficking in food assistance benefits. The penalty for any individual convicted of trafficking in food assistance benefits of $500 or more shall be permanent disqualification.

65.46(3) Receiving or attempting to receive multiple benefits. An individual found to have made a fraudulent statement or representation with respect to identity or residency in order to receive multiple benefits shall be ineligible to participate in the food assistance program for a period of ten years.

65.46(4) Fleeing felons and probation or parole violators. Rescinded IAB 10/3/01, effective 10/1/01.

65.46(5) Conviction of trading firearms, ammunition or explosives for benefits. The penalty for any individual convicted of trading firearms, ammunition or explosives for food assistance benefits shall be permanent disqualification.

441—65.47(234) Eligibility of noncitizens. Rescinded IAB 5/2/01, effective 6/1/01.

441—65.48(234) Sponsored aliens. Rescinded IAB 5/2/01, effective 6/1/01.

441—65.49(234) Providing information to law enforcement officials. Rescinded IAB 10/3/01, effective 10/1/01.
441—65.50(234) No increase in benefits. When a household’s means-tested federal, state, or local public assistance cash benefits are reduced because of a failure to perform an action required by the public assistance program, the department shall reduce the household’s food assistance benefit allotment by 10 percent as provided for in federal regulations at 7 CFR 273.11(j), (k), and (l) as amended to June 1, 2001, for the duration of the other program’s penalty.

441—65.51(234) State income and eligibility verification system. The department shall maintain and use an income and eligibility verification system (IEVS) as specified in 7 CFR 272.8 as amended to November 21, 2000.

441—65.52(234) Systematic alien verification for entitlements (SAVE) program. The department shall participate in the SAVE program established by the U.S. Bureau of Citizenship and Immigration Service (BCIS) as specified in 7 CFR 272.11 as amended to November 21, 2000, in order to verify the validity of documents provided by aliens applying for food assistance benefits with the central data files maintained by BCIS.

These rules are intended to implement Iowa Code section 234.12.

441—65.53 to 65.100  Reserved.

DIVISION II

[Prior to 10/13/93, 441—65.1(234) to 65.41(234)]

[Filed 5/7/97, effective 7/1/97]
[Filed 2/25/72; amended 4/7/72]
[Filed 2/19/76, Notice 1/12/76—published 3/8/76, effective 4/12/76]
[Filed emergency 8/2/79—published 8/22/79, effective 8/2/79]
[Filed emergency 12/7/79—published 12/26/79, effective 1/1/80]
[Filed emergency 1/23/80—published 2/20/80, effective 1/23/80]
[Filed 5/5/80, Notice 3/5/80—published 5/28/80, effective 7/2/80]
[Filed emergency 6/30/80—published 7/23/80, effective 6/30/80]
[Filed emergency 8/29/80—published 9/17/80, effective 8/29/80]
[Filed emergency 12/19/80—published 1/7/81, effective 1/1/81]
[Filed emergency 2/27/81—published 3/18/81, effective 2/27/81]
[Filed 3/4/81, Notice 2/4/81—published 4/15/81, effective 6/1/81]
[Filed emergency after Notice 6/1/81, Notice 4/1/81—published 6/24/81, effective 6/1/81]
[Filed emergency after Notice 6/2/81, Notice 4/1/81—published 6/24/81, effective 7/1/81]
[Filed 6/2/81, Notice 3/4/81—published 6/24/81, effective 8/1/81]
[Filed emergency 6/30/81—published 7/22/81, effective 7/1/81]
[Filed emergency 9/25/81—published 10/14/81, effective 10/1/81]
[Filed 10/23/81, Notice 8/19/81—published 11/11/81, effective 1/1/82]
[Filed 11/20/81, Notice 10/14/81—published 12/9/81, effective 2/1/82]
[Filed emergency 12/3/81—published 12/23/81, effective 1/1/82]
[Filed emergency 3/31/82—published 4/28/82, effective 4/1/82]
[Filed emergency 7/1/82—published 7/21/82, effective 7/1/82]
[Filed emergency 7/30/82—published 8/18/82, effective 7/30/82]
[Filed 8/20/82, Notice 6/23/82—published 9/15/82, effective 10/20/82]
[Filed emergency 9/23/82—published 10/13/82, effective 9/23/82]
[Filed emergency 12/17/82—published 1/5/83, effective 1/1/83]
[Filed emergency 1/14/83—published 2/2/83, effective 2/1/83]
[Filed emergency 3/31/83—published 4/27/83, effective 4/1/83]
[Filed without Notice 4/21/83—published 5/11/83, effective 7/1/83]
[Filed emergency 5/20/83—published 6/8/83, effective 6/1/83]
[Filed 7/29/83, Notice 4/27/83—published 8/17/83, effective 10/1/83]
[Filed 9/1/83, Notice 7/20/83—published 9/28/83, effective 11/2/83]
[Filed emergency 9/26/83—published 10/12/83, effective 10/1/83]
[Filed 12/16/83, Notice 11/9/83—published 1/4/84, effective 2/8/84]
[Filed 4/2/84, Notices 10/12/83, 12/7/83—published 4/25/84, effective 6/1/84]
[Filed 5/31/84, Notice 4/11/84—published 6/20/84, effective 8/1/84]
[Filed emergency 6/15/84—published 7/4/84, effective 7/1/84]
[Filed 8/31/84, Notice 7/4/84—published 9/26/84, effective 11/1/84]
[Filed emergency 11/1/84—published 11/21/84, effective 11/1/84]
[Filed emergency 12/11/84—published 1/2/85, effective 1/1/85]
[Filed 1/21/85, Notice 11/21/84—published 2/13/85, effective 4/1/85]
[Filed emergency 2/19/85—published 3/13/85, effective 3/1/85]
[Filed emergency 3/4/85—published 3/27/85, effective 4/1/85]
[Filed 3/4/85, Notice 12/19/84—published 3/27/85, effective 5/1/85]
[Filed 3/4/85, Notice 1/2/85—published 3/27/85, effective 5/1/85]
[Filed emergency 3/22/85—published 4/10/85, effective 4/1/85]
[Filed 3/22/85, Notice 2/13/85—published 4/10/85, effective 6/1/85]
[Filed 5/29/85, Notices 3/27/85—published 6/19/85, effective 8/1/85]
[Filed emergency 7/26/85—published 8/14/85, effective 8/1/85]
[Filed 7/26/85, Notice 6/5/85—published 8/14/85, effective 10/1/85]
[Filed 10/1/85, Notice 8/14/85—published 10/23/85, effective 12/1/85]
[Filed 1/22/86, Notice 12/4/85—published 2/12/86, effective 4/1/86]
[Filed emergency 3/21/86—published 4/9/86, effective 3/21/86]
[Filed emergency 4/29/86 after Notice 3/12/86—published 5/21/86, effective 5/1/86]
[Filed emergency 5/28/86 after Notice 4/9/86—published 6/18/86, effective 6/1/86]
[Filed emergency 6/20/86 after Notice 4/23/86—published 7/16/86, effective 7/1/86]
[Filed emergency 6/20/86—published 7/16/86, effective 7/1/86]
[Filed emergency 7/25/86—published 8/13/86, effective 8/1/86]
[Filed emergency 9/26/86 after Notice 4/9/86—published 10/22/86, effective 9/26/86]
[Filed emergency 9/26/86—published 10/22/86, effective 10/1/86]
[Filed 9/26/86, Notice 8/13/86—published 10/22/86, effective 12/1/86]
[Filed 11/14/86, Notice 10/8/86—published 12/3/86, effective 2/1/87]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed emergency 1/15/87—published 2/11/87, effective 2/1/87]
[Filed 1/15/87, Notice 12/3/86—published 2/11/87, effective 4/1/87]
[Filed emergency 2/25/87—published 3/25/87, effective 2/25/87]
[Filed emergency 3/26/87—published 4/22/87, effective 4/1/87]
[Filed emergency 4/23/87—published 5/20/87, effective 4/23/87]
[Filed 5/29/87, Notice 4/22/87—published 6/17/87, effective 8/1/87]
[Filed 7/24/87, Notice 5/20/87—published 8/12/87, effective 10/1/87]
[Filed without Notice 8/28/87—published 9/23/87, effective 11/1/87]
[Filed 9/24/87, Notice 8/12/87—published 10/21/87, effective 12/1/87]
[Filed 11/25/87, Notice 9/23/87—published 12/16/87, effective 2/1/88]
[Filed without Notice 11/25/87—published 12/16/87, effective 2/1/88]
[Filed emergency 9/1/88—published 9/21/88, effective 9/1/88]
[Filed emergency 9/21/88—published 10/19/88, effective 10/1/88]
[Filed without Notice 10/27/88—published 11/16/88, effective 1/1/89]
[Filed without Notice 12/8/88—published 12/28/88, effective 2/1/89]
[Filed emergency 2/16/89—published 3/8/89, effective 2/16/89]
[Filed 4/13/89, Notice 2/22/89—published 5/3/89, effective 7/1/89]
[Filed emergency 9/15/89—published 10/4/89, effective 10/1/89]
[Filed 11/20/89, Notices 9/20/89, 10/4/89—published 12/13/89, effective 2/1/90]
[Filed emergency 2/16/90—published 3/7/90, effective 4/1/90]
[Filed 4/13/90, Notice 3/7/90—published 5/2/90, effective 7/1/90]
[Filed 4/11/91, Notices 2/6/91, 3/6/91—published 5/1/91, effective 7/1/91]
[Filed emergency 7/10/91 after Notice 5/15/91—published 8/7/91, effective 8/1/91]
[Filed without Notice 9/18/91—published 10/16/91, effective 11/21/91]
[Filed emergency 10/10/91 after Notice 8/21/91—published 10/30/91, effective 11/1/91]
[Filed emergency 10/10/91—published 10/30/91, effective 11/21/91]
[Filed 10/10/91, Notice 9/4/91—published 10/30/91, effective 1/1/92]
[Filed 1/16/92, Notice 9/18/91—published 2/5/92, effective 4/1/92]
[Filed 1/29/92, Notice 10/16/91—published 2/19/92, effective 3/25/92]
[Filed emergency 5/13/92—published 6/10/92, effective 5/14/92]
[Filed 7/17/92, Notice 6/10/92—published 8/5/92, effective 10/1/92]
[Filed emergency 10/15/92 after Notice 8/19/92—published 11/11/92, effective 11/1/92]
[Filed 10/15/92, Notice 8/19/92—published 11/11/92, effective 12/16/92]
[Filed emergency 9/17/93—published 10/13/93, effective 10/1/93]
[Filed 12/16/93, Notice 10/13/93—published 1/5/94, effective 3/1/94]
[Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]
[Filed emergency 8/12/94—published 8/31/94, effective 9/1/94]
[Filed emergency 10/12/94—published 11/9/94, effective 11/1/94]
[Filed 10/12/94, Notice 8/31/94—published 11/9/94, effective 1/1/95]
[Filed emergency 11/9/94—published 12/7/94, effective 12/1/94]
[Filed emergency 1/11/95 after Notice 11/23/94—published 2/1/95, effective 2/1/95]
[Filed 1/11/95, Notice 11/23/94—published 2/1/95, effective 4/1/95]
[Filed 2/16/95, Notice 11/23/94—published 3/15/95, effective 5/1/95]
[Filed emergency 9/25/95—published 10/11/95, effective 10/1/95]
[Filed emergency 11/16/95—published 12/6/95, effective 12/1/95]
[Filed 11/16/95, Notice 10/11/95—published 12/6/95, effective 2/1/96]
[Filed emergency 1/10/96—published 1/31/96, effective 2/1/96]
[Filed 1/10/96, Notice 12/6/95—published 1/31/96, effective 4/1/96]
[Filed 3/13/96, Notice 1/31/96—published 4/10/96, effective 6/1/96]
[Filed 8/15/96, Notice 5/8/96—published 9/11/96, effective 11/1/96]
[Filed emergency 9/19/96—published 10/9/96, effective 9/21/96]
[Filed without Notice 9/19/96—published 10/9/96, effective 11/22/96]
[Filed emergency 10/9/96—published 11/6/96, effective 10/10/96]
[Filed 12/12/96, Notices 10/9/96, 11/6/96—published 1/1/97, effective 3/1/97]
[Filed 4/11/97, Notice 2/12/97—published 5/7/97, effective 7/1/97]
[Filed emergency 6/10/98—published 7/1/98, effective 7/1/98]
[Filed 6/10/98, Notice 5/6/98—published 7/1/98, effective 8/5/98]
[Filed 8/12/98, Notices 6/17/98, 7/1/98—published 9/9/98, effective 11/1/98]
[Filed emergency 10/14/98—published 11/4/98, effective 11/1/98]
[Filed 1/12/00, Notice 12/1/99—published 2/9/00, effective 4/1/00]
[Filed emergency 3/8/00—published 4/5/00, effective 4/1/00]
[Filed 6/8/00, Notice 4/5/00—published 6/28/00, effective 9/1/00]
[Filed emergency 2/21/01—published 3/21/01, effective 4/1/01]
[Filed emergency 4/11/01 after Notice 3/7/01—published 5/2/01, effective 6/1/01]
[Filed 5/9/01, Notice 3/21/01—published 5/30/01, effective 8/1/01]
[Filed emergency 9/11/01 after Notice 7/25/01—published 10/3/01, effective 10/1/01]
[Filed 9/11/01, Notice 7/11/01—published 10/3/01, effective 4/1/02]
[Filed 2/14/02, Notice 12/26/01—published 3/6/02, effective 5/1/02]
[Filed emergency 8/15/02 after Notice 6/26/02—published 9/4/02, effective 10/1/02]
[Filed 8/15/02, Notice 6/26/02—published 9/4/02, effective 12/1/02]
[Filed emergency 9/12/02 after Notice 7/24/02—published 10/2/02, effective 10/1/02]
[Filed emergency 12/12/02 after Notice 10/30/02—published 1/8/03, effective 1/1/03]
[Filed 2/13/03, Notice 12/25/02—published 3/5/03, effective 5/1/03]
[Filed emergency 3/14/03 after Notice 1/22/03—published 4/2/03, effective 4/1/03]
[Filed 7/10/03, Notice 5/28/03—published 8/6/03, effective 10/1/03]
[Filed 8/26/03, Notice 6/25/03—published 9/17/03, effective 11/1/03]
[Filed emergency 11/19/03 after Notice 10/1/03—published 12/10/03, effective 12/1/03]
[Filed emergency 6/14/04—published 7/7/04, effective 7/1/04]
[Filed emergency 8/12/04—published 9/1/04, effective 8/20/04]
[Filed 9/23/04, Notice 7/7/04—published 10/13/04, effective 11/17/04]
[Filed 10/14/04, Notice 9/1/04—published 11/10/04, effective 12/15/04]
[Filed emergency 1/13/05—published 2/2/05, effective 3/1/05]
[Filed 4/15/05, Notice 2/2/05—published 5/11/05, effective 6/15/05]
[Filed emergency 11/16/05—published 12/7/05, effective 12/1/05]
[Filed emergency 9/14/06—published 10/11/06, effective 10/1/06]
[Filed 1/12/07, Notice 11/22/06—published 2/14/07, effective 4/1/07]
[Filed emergency 2/15/07—published 3/14/07, effective 3/1/07]
[Filed 5/10/07, Notice 3/14/07—published 6/6/07, effective 7/11/07]
[Filed 7/12/07, Notice 5/23/07—published 8/1/07, effective 10/1/07]
[Filed emergency 9/12/07—published 10/10/07, effective 10/1/07]
[Filed 1/9/08, Notice 11/7/07—published 1/30/08, effective 3/5/08]
[Filed emergency 8/15/08—published 9/10/08, effective 10/1/08]
[Filed 11/12/08, Notice 9/10/08—published 12/3/08, effective 1/1/09]
[Filed ARC 7928B (Notice ARC 7724B, IAB 4/22/09), IAB 7/1/09, effective 9/1/09]
[Filed Emergency After Notice ARC 8500B (Notice ARC 8272B, IAB 11/4/09), IAB 2/10/10, effective 3/1/10]
[Filed Emergency After Notice ARC 8556B (Notice ARC 8407B, IAB 12/16/09), IAB 3/10/10, effective 2/10/10]
[Filed Emergency After Notice ARC 8712B (Notice ARC 8535B, IAB 2/24/10), IAB 5/5/10, effective 4/15/10]
[Filed ARC 8992B (Notice ARC 8758B, IAB 5/19/10), IAB 8/11/10, effective 10/1/10]
[Filed ARC 9173B (Notice ARC 9020B, IAB 8/25/10), IAB 11/3/10, effective 1/1/11]
[Filed ARC 0148C (Notice ARC 0048C, IAB 3/21/12), IAB 6/13/12, effective 8/1/12]
[Filed ARC 1148C (Notice ARC 0916C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
[Filed ARC 4573C (Notice ARC 4439C, IAB 5/22/19), IAB 7/31/19, effective 9/4/19]

1 Two ARC
2 Amendments to subrules 65.30(5) and 65.130(7) and rules 65.32(234) and 65.132(234) effective 10/1/96.
3 Subrules 65.8(11) and 65.108(11) effective 1/1/97.
CHAPTER 75
CONDITIONS OF ELIGIBILITY
[Ch 75, 1973 IDR, renumbered as Ch 90]
[Prior to 7/1/83, Social Services[770] Ch 75]
[Prior to 2/11/87, Human Services[498]]

PREAMBLE
This chapter establishes the conditions of eligibility for the medical assistance program administered by the department of human services pursuant to Iowa Code chapter 249A and addresses related matters. 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 of Title XIX requirements granted by the Secretary of the U.S. Department of Health and Human Services. 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 of Title XIX or the terms of the waiver shall prevail.

[ARC 1134C, IAB 10/30/13, effective 10/2/13]

DIVISION I
GENERAL CONDITIONS OF ELIGIBILITY, COVERAGE GROUPS, AND SSI-RELATED PROGRAMS

441—75.1(249A) Persons covered.
75.1(1) Persons receiving refugee cash assistance. Medical assistance shall be available to all recipients of refugee cash assistance. Recipient means a person for whom a refugee cash assistance (RCA) payment is received and includes persons deemed to be receiving RCA. Persons deemed to be receiving RCA are:

a. Persons denied RCA because the amount of payment would be less than $10.

b. Rescinded IAB 7/30/08, effective 10/1/08.

c. Persons who are eligible in every respect for refugee cash assistance (RCA) as provided in Chapter 60, but who do not receive RCA because they did not make application for the assistance.

75.1(2) Rescinded IAB 10/8/97, effective 12/1/97.

75.1(3) Persons who are ineligible for Supplemental Security Income (SSI) because of requirements that do not apply under Title XIX of the Social Security Act. Medicaid shall be available to persons who would be eligible for SSI except for an eligibility requirement used in that program which is specifically prohibited under Title XIX.

75.1(4) Beneficiaries of Title XVI of the Social Security Act (supplemental security income for the aged, blind and disabled) and mandatory state supplementation. Medical assistance will be available to all beneficiaries of the Title XVI program and those receiving mandatory state supplementation.

75.1(5) Persons receiving care in a medical institution who were eligible for Medicaid as of December 31, 1973. Medicaid shall be available to all persons receiving care in a medical institution who were Medicaid members as of December 31, 1973. Eligibility of these persons will continue as long as they continue to meet the eligibility requirements for the applicable assistance programs (old-age assistance, aid to the blind or aid to the disabled) in effect on December 31, 1973.

75.1(6) Persons who would be eligible for supplemental security income (SSI), state supplementary assistance (SSA), or the family medical assistance program (FMAP) except for their institutional status. Medicaid shall be available to persons receiving care in a medical institution who would be eligible for SSI, SSA, or FMAP if they were not institutionalized.

75.1(7) Persons receiving care in a medical facility who would be eligible under a special income standard.

a. Subject to paragraphs “b” and “c” below, Medicaid shall be available to persons who:

(1) Meet level of care requirements as set forth in rules 441—78.3(249A), 441—81.3(249A), and 441—82.7(249A).

(2) Receive care in a hospital, nursing facility, psychiatric medical institution, intermediate care facility for the mentally retarded, or Medicare-certified skilled nursing facility.
(3) Have gross countable monthly income that does not exceed 300 percent of the federal supplemental security income benefits for one.

(4) Either meet all supplemental security income (SSI) eligibility requirements except for income or are under age 21. FMAP policies regarding income and age do not apply when determining eligibility for persons under the age of 21.

b. For all persons in this coverage group, income shall be considered as provided for SSI-related coverage groups under subrule 75.13(2). In establishing eligibility for persons aged 21 or older for this coverage group, resources shall be considered as provided for SSI-related coverage groups under subrule 75.13(2).

c. Eligibility for persons in this group shall not exist until the person has been institutionalized for a period of 30 consecutive days and shall be effective no earlier than the first day of the month in which the 30-day period begins. A “period of 30 days” is defined as being from 12 a.m. of the day of admission to the medical institution, and ending no earlier than 12 midnight of the thirtieth day following the beginning of the period.

(1) A person who enters a medical institution and who dies prior to completion of the 30-day period shall be considered to meet the 30-day period provision.

(2) Only one 30-day period is required to establish eligibility during a continuous stay in a medical institution. Discharge during a subsequent month, creating a partial month of care, does not affect eligibility for that partial month regardless of whether the eligibility determination was completed prior to discharge.

(3) A temporary absence of not more than 14 full consecutive days during which the person remains under the jurisdiction of the institution does not interrupt the 30-day period. In order to remain “under the jurisdiction of the institution” a person must first have been physically admitted to the institution.

75.1(8) Certain persons essential to the welfare of Title XVI beneficiaries. Medical assistance will be available to the person living with and essential to the welfare of a Title XIX beneficiary provided the essential person was eligible for medical assistance as of December 31, 1973. The person will continue to be eligible for medical assistance as long as the person continues to meet the definition of “essential person” in effect in the public assistance program on December 31, 1973.

75.1(9) Individuals receiving state supplemental assistance. Medical assistance shall be available to all recipients of state supplemental assistance as authorized by Iowa Code chapter 249.

75.1(10) Individuals under age 21 living in a licensed foster care facility or in a private home pursuant to a subsidized adoption arrangement for whom the department has financial responsibility in whole or in part. When Iowa is responsible for foster care payment for a child pursuant to Iowa Code section 234.35 and rule 441—156.20(234) or has negotiated an adoption assistance agreement for a child pursuant to rule 441—201.5(600), medical assistance shall be available to the child if:

a. The child lives in Iowa and is not otherwise eligible under a category for which federal financial participation is available; or

b. The child lives in another state and is not eligible for benefits from the other state pursuant to a program funded under Title XIX of the federal Social Security Act, notwithstanding the residency requirements of 441—75.10(249A) and 441—75.53(249A).

75.1(11) Individuals living in a court-approved subsidized guardianship home for whom the department has financial responsibility in whole or in part. When Iowa is responsible for a subsidized guardianship payment for a child pursuant to 441—Chapter 204, medical assistance will be available to the child under this subrule if the child is living in a court-approved subsidized guardianship home and either:

a. The child lives in Iowa and is not eligible for medical assistance under a category for which federal financial participation is available due to reasons other than:

(1) Failure to provide information, or

(2) Failure to comply with other procedural requirements; or

b. Notwithstanding the residency requirements of 441—75.10(249A) and 441—75.53(249A), the child lives in another state and is not eligible for benefits from the other state pursuant to a program funded under Title XIX of the federal Social Security Act due to reasons other than:
(1) Failure to provide information, or
(2) Failure to comply with other procedural requirements.

75.1(12) Persons ineligible due to October 1, 1972, social security increase. Medical assistance will be available to individuals and families whose assistance grants were canceled as a result of the increase in social security benefits October 1, 1972, as long as these individuals and families would be eligible for an assistance grant if the increase were not considered.

75.1(13) Persons who would be eligible for supplemental security income or state supplementary assistance but for social security cost-of-living increases received. Medical assistance shall be available to all current social security recipients who meet the following conditions:

a. They were entitled to and received concurrently in any month after April 1977 supplemental security income and social security or state supplementary assistance and social security, and
b. They subsequently lost eligibility for supplemental security income or state supplementary assistance, and
c. They would be eligible for supplemental security income or state supplementary assistance if all of the social security cost-of-living increases which they and their financially responsible spouses, parents, and dependent children received since they were last eligible for and received social security and supplemental security income (or state supplementary assistance) concurrently were deducted from their income. Spouses, parents, and dependent children are considered financially responsible if their income would be considered in determining the applicant’s eligibility.

75.1(14) Family medical assistance program (FMAP). Medicaid shall be available to children who meet the provisions of rule 441—75.54(249A) and to the children’s specified relatives who meet the provisions of subrule 75.54(2) and rule 441—75.55(249A) if the following criteria are met.

a. In establishing eligibility of specified relatives for this coverage group, resources are considered in accordance with the provisions of rule 441—75.56(249A) and shall not exceed $2,000 for applicant households or $5,000 for member households. In establishing eligibility for children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded.
b. Income is considered in accordance with rule 441—75.57(249A) and does not exceed needs standards established in rule 441—75.58(249A).
c. Rescinded IAB 11/1/00, effective 1/1/01.

75.1(15) Child medical assistance program (CMAP). Medicaid shall be available to persons under the age of 21 if the following criteria are met:

a. Financial eligibility shall be determined for the family size of which the child is a member using the income standards in effect for the family medical assistance program (FMAP) unless otherwise specified. Income shall be considered as provided in rule 441—75.57(249A). Additionally, the earned income disregards as provided in paragraphs 75.57(2)”a,” “b,” “c,” and “d” shall be allowed for those persons whose income is considered in establishing eligibility for the persons under the age of 21 and whose needs must be included in accordance with paragraph 75.58(1)”a” but who are not eligible for Medicaid. Resources of all persons in the eligible group, regardless of age, shall be disregarded. Unless a family member is voluntarily excluded in accordance with the provisions of rule 441—75.59(249A), family size shall be determined as follows:

(1) If the person under the age of 21 is pregnant and the pregnancy has been verified in accordance with rule 441—75.17(249A), the unborn child (or children if more than one) is considered a member of the family for purposes of establishing the number of persons in the family.

(2) A “man-in-the-house” who is not married to the mother of the unborn child is not considered a member of the unborn child’s family for the purpose of establishing the number of persons in the family. His income and resources are not automatically considered, regardless of whether or not he is the legal or natural father of the unborn child. However, income and resources made available to the mother of the unborn child by the “man-in-the-house” shall be considered in determining eligibility for the pregnant individual.

(3) Unless otherwise specified, when the person under the age of 21 is living with a parent(s), the family size shall consist of all family members as defined by the family medical assistance program in accordance with paragraph 75.57(8)”c” and subrule 75.58(1).
Application for Medicaid shall be made by the parent(s) when the person is residing with them. A person shall be considered to be living with the parent(s) when the person is temporarily absent from the parent’s(s’) home as defined in subrule 75.53(4). If the person under the age of 21 is married or has been married, the needs, income and resources of the person’s parent(s) and any siblings in the home shall not be considered in the eligibility determination unless the marriage was annulled.

(4) When a person is living with a spouse the family size shall consist of that person, the spouse and any of their children, including any unborn children.

(5) Siblings under the age of 21 who live together shall be considered in the same filing unit for the purpose of establishing eligibility under this rule unless one sibling is married or has been married, in which case, the married sibling shall be considered separately unless the marriage was annulled.

(6) When a person is residing in a household in which some members are receiving FMAP under the provisions of subrule 75.1(14) or MAC under the provisions of subrule 75.1(28), and when the person is not included in the FMAP or MAC eligible group, the family size shall consist of the person and all other family members as defined above except those in the FMAP or MAC eligible group.

b. Rescinded IAB 9/6/89, effective 11/1/89.

c. Rescinded IAB 11/1/89, effective 1/1/90.

d. A person is eligible for the entire month in which the person’s twenty-first birthday occurs unless the birthday falls on the first day of the month.

e. Living with a specified relative as provided in subrule 75.54(2) shall not be considered when determining eligibility for persons under this coverage group.

75.1(16) Children receiving subsidized adoption payments from states providing reciprocal medical assistance benefits. Medical assistance shall be available to children under the age of 21 for whom an adoption assistance agreement with another state is in effect if all of the following conditions are met:

a. The child is residing in Iowa in a private home with the child’s adoptive parent or parents.

b. Benefits funded under Title IV-E of the Social Security Act are not being paid for the child by any state.

c. Another state currently has an adoption assistance agreement in effect for the child.

d. The state with the adoption assistance agreement:

(1) Is a member of the interstate compact on adoption and medical assistance (ICAMA); and

(2) Provides medical assistance benefits pursuant to a program funded under Title XIX of the Social Security Act, under the optional group at Section 1902(a)(10)(A)(i)(VIII) of the Act, to children residing in that state (at least until age 18) for whom there is a state adoption assistance agreement in effect with the state of Iowa other than under Title IV-E of the Social Security Act.

75.1(17) Persons who meet the income and resource requirements of the cash assistance programs. Medicaid shall be available to the following persons who meet the income and resource guidelines of supplemental security income or refugee cash assistance, but who are not receiving cash assistance:

a. Aged and blind persons, as defined at subrule 75.13(2).

b. Disabled persons, as defined at rule 441—75.20(249A).

In establishing eligibility for children for this coverage group based on eligibility for SSI, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for adults for this coverage group, resources shall be considered as provided for SSI-related coverage groups under subrule 75.13(2) or as under refugee cash assistance.

75.1(18) Persons eligible for waiver services. Medicaid shall be available to recipients of waiver services as defined in 441—Chapter 83.

75.1(19) Persons and families terminated from aid to dependent children (ADC) prior to April 1, 1990, due to discontinuance of the $30 or the $30 and one-third earned income disregards. Rescinded IAB 6/12/91, effective 8/1/91.

75.1(20) Newborn children. Medicaid shall be available without an application to newborn children of women who are determined eligible for Medicaid for the month of the child’s birth or for three-day emergency services for labor and delivery for the child’s birth. Effective April 1, 2009, eligibility begins
with the month of the birth and continues through the month of the first birthday as long as the child remains an Iowa resident.

a. The department shall accept any written or verbal statement as verification of the newborn’s birth date unless the birth date is questionable.

b. In order for Medicaid to continue after the month of the first birthday, a redetermination of eligibility shall be completed.

75.1(21) Persons and families ineligible for the family medical assistance program (FMAP) in whole or in part because of child or spousal support. Medicaid shall be available for an additional four months to persons and families who become ineligible for FMAP because of income from child support, alimony, or contributions from a spouse if the person or family member received FMAP in at least three of the six months immediately preceding the month of cancellation.

a. The four months of extended Medicaid coverage begin the day following termination of FMAP eligibility.

b. When ineligibility is determined to occur retroactively, the extended Medicaid coverage begins with the first month in which FMAP eligibility was erroneously granted.

c. Rescinded IAB 10/1/95, effective 10/1/95.

75.1(22) Refugee spenddown participants. Rescinded IAB 10/11/95, effective 10/1/95.

75.1(23) Persons who would be eligible for supplemental security income or state supplementary assistance but for increases in social security benefits because of elimination of the actuarial reduction formula and cost-of-living increases received. Medical assistance shall be available to all current social security recipients who meet the following conditions. They:

a. Were eligible for a social security benefit in December of 1983.

b. Were eligible for and received a widow’s or widower’s disability benefit and supplemental security income or state supplementary assistance for January of 1984.

c. Became ineligible for supplemental security income or state supplementary assistance because of an increase in their widow’s or widower’s benefit which resulted from the elimination of the reduction factor in the first month in which the increase was paid and in which a retroactive payment of that increase for prior months was not made.

d. Have been continuously eligible for a widow’s or widower’s benefit from the first month the increase was received.

e. Would be eligible for supplemental security income or state supplementary assistance benefits if the amount of the increase from elimination of the reduction factor and any subsequent cost-of-living adjustments were disregarded.

f. Submit an application prior to July 1, 1988, on Form 470-0442, Application for Medical Assistance or State Supplementary Assistance.

75.1(24) Postpartum eligibility for pregnant women. Medicaid shall continue to be available, without an application, for 60 days beginning with the last day of pregnancy and throughout the remaining days of the month in which the 60-day period ends, to a woman who had applied for Medicaid prior to the end of her pregnancy and was subsequently determined eligible for Medicaid for the month in which the pregnancy ended.

a. Postpartum Medicaid shall only be available to a woman who is not eligible for another coverage group after the pregnancy ends.

b. The woman shall not be required to meet any income or resource criteria during the postpartum period.

c. When the sixtieth day is not on the last day of the month the woman shall be eligible for Medicaid for the entire month.

75.1(25) Persons who would be eligible for supplemental security income or state supplementary assistance except that they receive child’s social security benefits based on disability. Medical assistance shall be available to persons who receive supplemental security income (SSI) or state supplementary assistance (SSA) after their eighteenth birthday because of a disability or blindness which began before age 22 and who would continue to receive SSI or SSA except that they become entitled to or receive an increase in social security benefits from a parent’s account.
75.1(26) Rescinded IAB 10/8/97, effective 12/1/97.

75.1(27) Widows and widowers who are no longer eligible for supplemental security income or state supplementary assistance because of the receipt of social security benefits. Medicaid shall be available to widows and widowers who meet the following conditions:

a. They have applied for and received or were considered recipients of supplemental security income or state supplementary assistance.

b. They apply for and receive Title II widow’s or widower’s insurance benefits or any other Title II old age or survivor’s benefits, if eligible for widow’s or widower’s benefits.


d. They were not entitled to Part A Medicare hospital insurance benefits at the time of application and receipt of Title II old age or survivor’s benefits. They are not currently entitled to Part A Medicare hospital insurance benefits.

e. They are no longer eligible for supplemental security income or state supplementary assistance solely because of the receipt of their social security benefits.

75.1(28) Pregnant women, infants and children (Mothers and Children (MAC)). Medicaid shall be available to all pregnant women, infants (under one year of age) and children who have not attained the age of 19 if the following criteria are met:

a. Income.

(1) Family income shall not exceed 300 percent of the federal poverty level for pregnant women and for infants (under one year of age). Family income shall not exceed 133 percent of the federal poverty level for children who have attained one year of age but who have not attained 19 years of age. Income to be considered in determining eligibility for pregnant women, infants, and children shall be determined according to family medical assistance program (FMAP) methodologies except that the three-step process for determining initial eligibility and the two-step process for determining ongoing eligibility, as described at rule 441—75.57(249A), shall not apply. “Family income” is the income remaining after disregards and deductions have been applied as provided in rule 441—75.57(249A).

(2) Moneys received as a lump sum, except as specified in subrules 75.56(4) and 75.56(7) and paragraphs 75.57(8) “b” and “c,” shall be treated in accordance with paragraphs 75.57(9) “b” and “c.”

(3) Unless otherwise specified, when the person under the age of 19 is living with a parent or parents, the family size shall consist of all family members as defined by the family medical assistance program.

Application for Medicaid shall be made by the parents when the person is residing with them. A person shall be considered to be living with the parents when the person is temporarily absent from the parent’s home as defined in subrule 75.53(4). If the person under the age of 19 is married or has been married, the needs, income and resources of the person’s parents and any siblings in the home shall not be considered in the eligibility determination unless the marriage was annulled.

(4) When a person under the age of 19 is living with a spouse, the family size shall consist of that person, the spouse, and any of their children.

(5) Siblings under the age of 19 who live together shall be considered in the same filing unit for the purpose of establishing eligibility under this subrule unless one sibling is married or has been married, in which case the married sibling shall be considered separately unless the marriage was annulled.

b. For pregnant women, resources shall not exceed $10,000 per household. In establishing eligibility for infants and children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for pregnant women for this coverage group, resources shall be considered in accordance with department of public health 641—subrule 75.4(2).

c. Rescinded IAB 9/6/89, effective 11/1/89.

d. Eligibility for pregnant women under this rule shall begin no earlier than the first day of the month in which conception occurred and in accordance with 441—76.5(249A).

e. The unborn child (children if more than one fetus exists) shall be considered when determining the number of persons in the household.
f. An infant shall be eligible through the month of the first birthday unless the birthday falls on the first day of the month. A child shall be eligible through the month of the nineteenth birthday unless the birthday falls on the first day of the month.

g. Rescinded IAB 11/1/89, effective 1/1/90.

h. When determining eligibility under this coverage group, living with a specified relative as specified at subrule 75.54(2) and the student provisions specified in subrule 75.54(1) do not apply.

i. A woman who had applied for Medicaid prior to the end of her pregnancy and was subsequently determined eligible for assistance under this coverage group for the month in which her pregnancy ended shall be entitled to receive Medicaid through the postpartum period in accordance with subrule 75.1(24).

j. If an infant loses eligibility under this coverage group at the time of the first birthday due to an inability to meet the income limit for children or if a child loses eligibility at the time of the nineteenth birthday, but the infant or child is receiving inpatient services in a medical institution, Medicaid shall continue under this coverage group for the duration of the time continuous inpatient services are provided.

75.1(29) Persons who are entitled to hospital insurance benefits under Part A of Medicare (Qualified Medicare Beneficiary program). Medicaid shall be available to persons who are entitled to hospital insurance under Part A of Medicare to cover the cost of the Medicare Part A and B premiums, coinsurance and deductibles, providing the following conditions are met:

a. The person’s monthly income does not exceed 100 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(1) The amount of income shall be determined as under the federal Supplemental Security Income (SSI) program.

(2) Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty line is published.

b. The person’s resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits. The amount of resources shall be determined as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4).

c. The effective date of eligibility is the first of the month after the month of decision.

75.1(30) Presumptive eligibility for pregnant women. A pregnant woman who is determined by a qualified provider to be presumptively eligible for Medicaid, based only on her statements regarding family income, shall be eligible for ambulatory prenatal care. Eligibility shall continue until the last day of the month following the month of the presumptive eligibility determination unless the pregnant woman is determined to be ineligible for Medicaid during this period based on a Medicaid application filed either before the presumptive eligibility determination or during this period. In this case, presumptive eligibility shall end on the date Medicaid ineligibility is determined. A pregnant woman who files a Medicaid application but withdraws that application before eligibility is determined has not been determined ineligible for Medicaid. The pregnant woman shall complete Form 470-2927 or 470-2927(S), Health Services Application, in order for the qualified provider to make the presumptive eligibility determination. The qualified provider shall complete Form 470-2629, Presumptive Medicaid Income Calculation, in order to establish that the pregnant woman’s family income is within the prescribed limits of the Medicaid program.

If the pregnant woman files a Medicaid application in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination, Medicaid shall continue until a decision of ineligibility is made on the application. Payment of claims for ambulatory prenatal care services provided to a pregnant woman under this subrule is not dependent upon a finding of Medicaid eligibility for the pregnant woman.
a. A qualified provider is defined as a provider who is eligible for payment under the Medicaid program and who meets all of the following criteria:

1. Provides one or more of the following services:
   1. Outpatient hospital services.
   2. Rural health clinic services (if contained in the state plan).
   3. Clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician.

2. Has been specifically designated by the department in writing as a qualified provider for the purposes of determining presumptive eligibility on the basis of the department’s determination that the provider is capable of making a presumptive eligibility determination based on family income.

3. Meets one of the following:
   1. Receives funds under the Migrant Health Centers or Community Health Centers (subsection 329 or subsection 330 of the Public Health Service Act) or the Maternal and Child Health Services Block Grant Programs (Title V of the Social Security Act) or the Health Services for Urban Indians Program (Title V of the Indian Health Care Improvement Act).
   2. Participates in the program established under the Special Supplemental Food Program for Women, Infants, and Children (subsection 17 of the Child Nutrition Act of 1966) or the Commodity Supplemental Food Program (subsection 4(a) of the Agriculture and Consumer Protection Act of 1973).
   3. Participates in a state perinatal program.
   4. Is an Indian health service office or a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act.

b. The provider shall complete Form 470-2579, Application for Authorization to Make Presumptive Medicaid Eligibility Determinations, and submit it to the department for approval in order to become certified as a provider qualified to make presumptive eligibility determinations. Once the provider has been approved as a provider qualified to make presumptive Medicaid eligibility determinations, Form 470-2582, Memorandum of Understanding Between the Iowa Department of Human Services and a Qualified Provider, shall be signed by the provider and the department.

c. Once the qualified provider has made a presumptive eligibility determination for a pregnant woman, the provider shall:
   1. Contact the department to obtain a state identification number for the pregnant woman who has been determined presumptively eligible.
   2. Notify the department in writing of the determination within five working days after the date the presumptive determination is made. A copy of the Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580 or 470-2580(S), shall be used for this purpose.
   3. Inform the pregnant woman in writing, at the time the determination is made, that if she chose not to apply for Medicaid on the Health Services Application, Form 470-2927 or 470-2927(S), she has until the last day of the month following the month of the preliminary determination to file an application with the department. A Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580, shall be issued by the qualified provider for this purpose.
   4. Forward copies of the Health Services Application, Form 470-2927 or 470-2927(S), to the appropriate offices for eligibility determinations if the pregnant woman indicated on the application that she was applying for any of the other programs listed on the application. These copies shall be forwarded within two working days from the date of the presumptive determination.
   
   d. In the event that a pregnant woman needing prenatal care does not appear to be presumptively eligible, the qualified provider shall inform the pregnant woman that she may file an application at the local department office if she wishes to have a formal determination made.

c. Presumptive eligibility shall end under any of the following conditions:
   1. The woman fails to file an application for Medicaid in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination.
   2. The woman files a Medicaid application by the last day of the month following the month of the presumptive eligibility determination and has been found ineligible for Medicaid.
   3. Rescinded IAB 5/1/91, effective 7/1/91.
The adequate and timely notice requirements and appeal rights associated with an application that is filed pursuant to rule 441—76.1(249A) shall apply to an eligibility determination made on the Medicaid application. However, notice requirements and appeal rights of the Medicaid program shall not apply to a woman who is:

(1) Issued a presumptive eligibility decision by a qualified provider.

(2) Determined to be presumptively eligible by a qualified provider and whose presumptive eligibility ends because the woman fails to file an application by the last day of the month following the month of the initial presumptive eligibility determination.

(3) Rescinded IAB 5/1/91, effective 7/1/91.

g. A woman shall not be determined to be presumptively eligible for Medicaid more than once per pregnancy.

75.1(31) Persons and families canceled from the family medical assistance program (FMAP) due to the increased earnings of the specified relative in the eligible group. Medicaid shall be available for a period of up to 12 additional months to families who are canceled from FMAP as provided in subrule 75.1(14) because the specified relative of a dependent child receives increased income from employment.

For the purposes of this subrule, “family” shall mean individuals living in the household whose needs and income were included in determining the FMAP eligibility of the household members at the time that the FMAP benefits were terminated. “Family” also includes those individuals whose needs and income would be taken into account in determining the FMAP eligibility of household members if the household were applying in the current month.

a. Increased income from employment includes:

(1) Beginning employment.

(2) Increased rate of pay.

(3) Increased hours of employment.

b. In order to receive transitional Medicaid coverage under these provisions, an FMAP family must have received FMAP during at least three of the six months immediately preceding the month in which ineligibility occurred.

c. The 12 months’ Medicaid transitional coverage begins the day following termination of FMAP eligibility.

d. When ineligibility is determined to occur retroactively, the transitional Medicaid coverage begins with the first month in which FMAP eligibility was erroneously granted, unless the provisions of paragraph “f” below apply.

e. Rescinded IAB 8/12/98, effective 10/1/98.

f. Transitional Medicaid shall not be allowed under these provisions when it has been determined that the member received FMAP in any of the six months immediately preceding the month of cancellation as the result of fraud. Fraud shall be defined in accordance with Iowa Code Supplement section 239B.14.

g. During the transitional Medicaid period, assistance shall be terminated at the end of the first month in which the eligible group ceases to include a child, as defined by the family medical assistance program.

h. If the family receives transitional Medicaid coverage during the entire initial six-month period and the department has received, by the twenty-first day of the fourth month, a complete Notice of Decision/Quarterly Income Report, Form 470-2663 or 470-2663(S), Medicaid shall continue for an additional six months, subject to paragraphs “g” and “i” of this subrule.

(1) If the department does not receive a completed form by the twenty-first day of the fourth month, assistance shall be canceled.

(2) A completed form is one that has all items answered, is signed, is dated, and is accompanied by verification as required in paragraphs 75.57(1) “f” and 75.57(2) “i.”

i. Medicaid shall end at the close of the first or fourth month of the additional six-month period if any of the following conditions exists:

(1) The department does not receive a complete Notice of Decision/Quarterly Income Report, Form 470-2663 or 470-2663(S), by the twenty-first day of the first month or the fourth month of the additional
six-month period as required in paragraph 75.1(31)“h,” unless the family establishes good cause for failure to report on a timely basis. Good cause shall be established when the family demonstrates that one or more of the following conditions exist:

1. There was a serious illness or death of someone in the family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. The family offers a good cause beyond the family’s control.
4. There was a failure to receive the department’s notification for a reason not attributable to the family. Lack of forwarding address is attributable to the family.

(2) The specified relative had no earnings in one or more of the previous three months, unless the lack of earnings was due to an involuntary loss of employment, illness, or there were instances where problems could negatively impact the client’s achievement of self-sufficiency as described at 441—subrule 93.133(4).

(3) It is determined that the family’s average gross earned income, minus child care expenses for the children in the eligible group necessary for the employment of the specified relative, during the immediately preceding three-month period exceeds 185 percent of the federal poverty level as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

(4) These provisions apply to specified relatives defined at paragraph 75.55(1)“a,” including:

(1) Any parent who is in the home. This includes parents who are included in the eligible group as well as those who are not.

(2) A stepparent who is included in the eligible group and who has assumed the role of the caretaker relative due to the absence or incapacity of the parent.

(3) A needy specified relative who is included in the eligible group.

(4) The timely notice requirements as provided in 441—subrule 76.4(1) shall not apply when it is determined that the family failed to meet the eligibility criteria specified in paragraph “g” or “i” above. Transitional Medicaid shall be terminated beginning with the first month following the month in which the family no longer met the eligibility criteria. An adequate notice shall be provided to the family when any adverse action is taken.

75.1(32) Persons and families terminated from refugee cash assistance (RCA) because of income earned from employment. Refugee medical assistance (RMA) shall be available as long as the eight-month limit for the refugee program is not exceeded to persons who are receiving RMA and who are canceled from the RCA program solely because a member of the eligible group receives income.

(1) An RCA recipient shall not be required to meet any minimum program participation time frames in order to receive RMA coverage under these provisions.

(2) A person who returns to the home after the family became ineligible for RCA may be included in the eligible group for RMA coverage if the person was included on the assistance grant the month the family became ineligible for RCA.

75.1(33) Qualified disabled and working persons. Medicaid shall be available to cover the cost of the premium for Part A of Medicare (hospital insurance benefits) for qualified disabled and working persons.

(1) Qualified disabled and working persons are persons who meet the following requirements:

(a) The person’s monthly income does not exceed 200 percent of the federal poverty level applicable to the family size involved.

(b) The person’s resources do not exceed twice the maximum amount allowed under the supplemental security income (SSI) program.

(c) The person is not eligible for any other Medicaid benefits.

(d) The person is entitled to enroll in Medicare Part A of Title XVIII under Section 1818A of the Social Security Act (as added by Section 6012 of OBRA 1989).

(b) The amount of the person’s income and resources shall be determined as under the SSI program.
75.1(34) **Specified low-income Medicare beneficiaries.** Medicaid shall be available to persons who are entitled to hospital insurance under Part A of Medicare to cover the cost of the Medicare Part B premium, provided the following conditions are met:

a. The person’s monthly income exceeds 100 percent of the federal poverty level but is less than 120 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

b. The person’s resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits.

c. The amount of income and resources shall be determined as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty level is published.

d. The effective date of eligibility shall be as set forth in rule 441—76.5(249A).

75.1(35) **Medically needy persons.**

a. **Coverage groups.** Subject to other requirements of this chapter, Medicaid shall be available to the following persons:

   (1) Pregnant women. Pregnant women who would be eligible for FMAP-related coverage groups except for excess income or resources. For FMAP-related programs, pregnant women shall have the unborn child or children counted in the household size as if the child or children were born and living with them.

   (2) FMAP-related persons under the age of 19. Persons under the age of 19 who would be eligible for an FMAP-related coverage group except for excess income.

   (3) CMAP-related persons under the age of 21. Persons under the age of 21 who would be eligible in accordance with subrule 75.1(15) except for excess income.

   (4) SSI-related persons. Persons who would be eligible for SSI except for excess income or resources.

   (5) FMAP-specified relatives. Persons whose income or resources exceed the family medical assistance program’s limit and who are a specified relative as defined at subrule 75.55(1) living with a child who is determined dependent.

b. **Resources and income of all persons considered.**

   (1) Resources of all specified relatives and of all potentially eligible individuals living together, except as specified at subparagraph 75.1(35) "b"(2) or who are excluded in accordance with the provisions of rule 441—75.59(249A), shall be considered in determining eligibility of adults. Resources of all specified relatives and of all potentially eligible individuals living together shall be disregarded in determining eligibility of children. Income of all specified relatives and of all potentially eligible individuals living together, except as specified at subparagraph 75.1(35) "b"(2) or who are excluded in accordance with the provisions of rule 441—75.59(249A), shall be considered in determining eligibility.

   (2) The amount of income of the responsible relative that has been counted as available to an FMAP household or SSI individual shall not be considered in determining the countable income for the medically needy eligible group.

   (3) The resource determination shall be according to subrules 75.5(3) and 75.5(4) when one spouse is expected to reside at least 30 consecutive days in a medical institution.

c. **Resources.**

   (1) The resource limit for adults in SSI-related households shall be $10,000 per household.

   (2) Disposal of resources for less than fair market value by SSI-related applicants or members shall be treated according to policies specified in rule 441—75.23(249A).

   (3) The resource limit for FMAP- or CMAP-related adults shall be $10,000 per household. In establishing eligibility for children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for adults for this coverage group, resources shall be considered according to department of public health 641—subrule 75.4(2).
(4) The resources of SSI-related persons shall be treated according to SSI policies.

(5) When a resource is jointly owned by SSI-related persons and FMAP-related persons, the resource shall be treated according to SSI policies for the SSI-related person and according to FMAP policies for the FMAP-related persons.

d. Income. All unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted shall be considered in determining initial and continuing eligibility.

(1) Income policies specified in subrules 75.57(1) through 75.57(8) and paragraphs 75.57(9) "b," "c," "g," "h," and "i" regarding treatment of earned and unearned income are applied to FMAP-related and CMAP-related persons when determining initial eligibility and for determining continuing eligibility unless otherwise specified. The three-step process for determining initial eligibility and the two-step process for determining ongoing eligibility, as described at rule 441—75.57(249A), shall not apply to medically needy persons.

(2) Income policies as specified in federal SSI regulations regarding treatment of earned and unearned income are applied to SSI-related persons when determining initial and continuing eligibility.

(3) The monthly income shall be determined prospectively unless actual income is available.

(4) The income for the certification period shall be determined by adding both months’ net income together to arrive at a total.

(5) The income for the retroactive certification period shall be determined by adding each month of the retroactive period to arrive at a total.

e. Medically needy income level (MNIL).

(1) The MNIL is based on 133 1/3 percent of the schedule of basic needs, as provided in subrule 75.58(2), with households of one treated as households of two, as follows:

<table>
<thead>
<tr>
<th>Number of Persons</th>
<th>MNIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$483</td>
</tr>
<tr>
<td>2</td>
<td>$483</td>
</tr>
<tr>
<td>3</td>
<td>$566</td>
</tr>
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<td>$666</td>
</tr>
<tr>
<td>5</td>
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</tr>
<tr>
<td>8</td>
<td>$975</td>
</tr>
<tr>
<td>9</td>
<td>$1058</td>
</tr>
<tr>
<td>10</td>
<td>$1158</td>
</tr>
</tbody>
</table>

Each additional person $116

(2) When determining household size for the MNIL, all potential eligibles and all individuals whose income is considered as specified in paragraph 75.1(35) “b” shall be included unless the person has been excluded according to the provisions of rule 441—75.59(249A).

(3) The MNIL for the certification period shall be determined by adding both months’ MNIL to arrive at a total. The MNIL for the retroactive certification period, when applicable, shall be determined by adding each month of the retroactive period to arrive at a total.

(4) The total net countable income for the certification period shall be compared to the total MNIL for the certification period based on family size as specified in subparagraph (2).

If the total countable net income is equal to or less than the total MNIL, the medically needy individuals shall be eligible for Medicaid.

If the total countable net income exceeds the total MNIL, the medically needy individuals shall not be eligible for Medicaid unless incurred medical expenses equal or exceed the difference between the net income and the MNIL.

(5) Effective date of approval. Eligibility during the certification period or the retroactive certification period when applicable shall be effective as of the first day of the first month of the certification period or the retroactive certification period when the medically needy income level (MNIL) is met.

e. Verification of medical expenses to be used in spenddown calculation. The applicant or member shall submit evidence of medical expenses that are for noncovered Medicaid services and for covered services incurred prior to the certification period to the department on a claim form, which shall be completed by the medical provider. In cases where the provider is uncooperative or where returning to the provider would constitute an unreasonable requirement on the applicant or member, the form shall be completed by the worker. Verification of medical expenses for the applicant or member that are covered Medicaid services and occurred during the certification period shall be submitted by the provider to the Iowa Medicaid enterprise on a claim form. The applicant or member shall inform the
provider of the applicant’s or member’s spenddown obligation at the time services are rendered or at the
time the applicant or member receives notification of a spenddown obligation. Verification of allowable
expenses incurred for transportation to receive medical care as specified in rule 441—78.13(249A) shall
be verified on Form 470-0394, Medical Transportation Claim.

Applicants who have not established that they met spenddown in the current certification period shall
be allowed 12 months following the end of the certification period to submit medical expenses for that
period or 12 months following the date of the notice of decision when the certification period had ended
prior to the notice of decision.

g. **Spenddown calculation.**

(1) Medical expenses that are incurred during the certification period may be used to meet
spenddown. Medical expenses incurred prior to a certification period shall be used to meet spenddown
if not already used to meet spenddown in a previous certification period and if all of the following
requirements are met. The expenses:

1. Remain unpaid as of the first day of the certification period.
2. Are not Medicaid-payable in a previous certification period or the retroactive certification
   period.
3. Are not incurred during any prior certification period with the exception of the retroactive period
   in which the person was conditionally eligible but did not meet spenddown.

Notwithstanding numbered paragraphs “1” through “3,” paid medical expenses from the retroactive
period can be used to meet spenddown in the retroactive period or in the certification period for the two
months immediately following the retroactive period.

(2) **Order of deduction.** Spenddown shall be adjusted when a bill for a Medicaid-covered service
incurred during the certification period has been applied to meet spenddown if a bill for a covered service
incurred prior to the certification period is subsequently received. Spenddown shall also be adjusted
when a bill for a noncovered Medicaid service is subsequently received with a service date prior to the
Medicaid-covered service. Spenddown shall be adjusted when an unpaid bill for a Medicaid-covered service
incurred during the certification period has been applied to meet spenddown if a paid bill for a
covered service incurred in the certification period is subsequently received with a service date prior to
the date of the notice of spenddown status.

If spenddown has been met and a bill is received with a service date after spenddown has been met,
the bill shall not be deducted to meet spenddown.

Incurred medical expenses, including those reimbursed by a state or political subdivision program
other than Medicaid, but excluding those otherwise subject to payment by a third party, shall be deducted
in the following order:

1. Medicare and other health insurance premiums, deductibles, or coinsurance charges.

**EXCEPTION:** When some of the household members are eligible for full Medicaid benefits under
the Health Insurance Premium Payment Program (HIPP), as provided in rule 441—75.21(249A), the
health insurance premium shall not be allowed as a deduction to meet the spenddown obligation of those
persons in the household in the medically needy coverage group.

2. An average statewide monthly standard deduction for the cost of medically necessary personal
care services provided in a licensed residential care facility shall be allowed as a deduction for
spenddown. These personal care services include assistance with activities of daily living such as
preparation of a special diet, personal hygiene and bathing, dressing, ambulation, toilet use, transferring,
eating, and managing medication.

The average statewide monthly standard deduction for personal care services shall be based on the
average per day rate of health care costs associated with residential care facilities participating in the
state supplementary assistance program for a 30.4-day month as computed in the Compilation of Various
Costs and Statistical Data (Category: All; Type of Care: Residential Care Facility; Location: All; Type of
Control: All). The average statewide standard deduction for personal care services used in the medically
needy program shall be updated and effective the first day of the first month beginning two full months
after the release of the Compilation of Various Costs and Statistical Data for the previous fiscal year.
3. Medical expenses for necessary medical and remedial services that are recognized under state law but not covered by Medicaid, chronologically by date of submission.
4. Medical expenses for acupuncture, chronologically by date of submission.
5. Medical expenses for necessary medical and remedial services that are covered by Medicaid, chronologically by date of submission.
   (3) When incurred medical expenses have reduced income to the applicable MNIL, the individuals shall be eligible for Medicaid.
   (4) Medical expenses reimbursed by a public program other than Medicaid prior to the certification period shall not be considered a medical deduction.
   h. Medicaid services. Persons eligible for Medicaid as medically needy will be eligible for all services covered by Medicaid except:
      (1) Care in a nursing facility or an intermediate care facility for the mentally retarded.
      (2) Care in an institution for mental disease.
      (3) Care in a Medicare-certified skilled nursing facility.
   i. Reviews. Reviews of eligibility shall be made for SSI-related, CMAP-related, and FMAP-related medically needy members with a zero spenddown as often as circumstances indicate but in no instance shall the period of time between reviews exceed 12 months.
      SSI-related, CMAP-related, and FMAP-related medically needy persons shall complete Form 470-3118 or 470-3118(S), Medicaid Review, as part of the review process when requested to do so by the department.
   j. Redetermination. When an SSI-related, CMAP-related, or FMAP-related member who has had ongoing eligibility because of a zero spenddown has income that exceeds the MNIL, a redetermination of eligibility shall be completed to change the member’s eligibility to a two-month certification with spenddown. This redetermination shall be effective the month the income exceeds the MNIL or the first month following timely notice.
      (1) The Health Services Application, Form 470-2927 or 470-2927(S), or the Health and Financial Support Application, Form 470-0462 or Form 470-0466(Spanish), shall be used to determine eligibility for SSI-related medically needy when an SSI recipient has been determined to be ineligible for SSI due to excess income or resources in one or more of the months after the effective date of the SSI eligibility decision.
      (2) All eligibility factors shall be reviewed on redeterminations of eligibility.
   k. Recertifications. A new application shall be made when the certification period has expired and there has been a break in assistance as defined at rule 441—75.25(249A). When the certification period has expired and there has not been a break in assistance, the person shall use the Medicaid Review, Form 470-3118 or 470-3118(S), to be recertified.
   l. Disability determinations. An applicant receiving social security disability benefits under Title II of the Social Security Act or railroad retirement benefits based on the Social Security Act definition of disability by the Railroad Retirement Board shall be deemed disabled without any further determination. In other cases under the medically needy program, the department shall conduct an independent determination of disability unless the applicant has been denied supplemental security income benefits based on lack of disability and does not allege either (1) a disabling condition different from or in addition to that considered by the Social Security Administration, or (2) that the applicant’s condition has changed or deteriorated since the most recent Social Security Administration determination.
      (1) In conducting an independent determination of disability, the department shall use the same criteria required by federal law to be used by the Social Security Administration of the United States Department of Health and Human Services in determining disability for purposes of Supplemental Security Income under Title XVI of the Social Security Act. The disability determination services bureau of the division of vocational rehabilitation shall make the initial disability determination on behalf of the department.
      (2) For an independent determination of disability, the applicant or the applicant’s authorized representative shall complete, sign and submit Form 470-4459 or 470-4459(S), Authorization to Disclose Information to the Department of Human Services, and either:
1. Form 470-2465, Disability Report for Adults, if the applicant is aged 18 or over; or
2. Form 470-3912, Disability Report for Children, if the applicant is under the age of 18.
3. In connection with any independent determination of disability, the department shall determine whether reexamination of the person’s medical condition will be necessary for periodic redeterminations of eligibility. When reexamination is required, the member or the member’s authorized representative shall complete and submit the same forms as required in subparagraph (2).

75.1(36) Expanded specified low-income Medicare beneficiaries. As long as 100 percent federal funding is available under the federal Qualified Individuals (QI) Program, Medicaid benefits to cover the cost of the Medicare Part B premium shall be available to persons who are entitled to Medicare Part A provided the following conditions are met:

a. The person is not otherwise eligible for Medicaid.

b. The person’s monthly income is at least 120 percent of the federal poverty level but is less than 135 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

c. The person’s resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits.

d. The amount of the income and resources shall be determined the same as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty level is published.

e. The effective date of eligibility shall be as set forth in rule 441—76.5(249A).

75.1(37) Home health specified low-income Medicare beneficiaries. Rescinded IAB 10/30/02, effective 1/1/03.

75.1(38) Continued Medicaid for disabled children from August 22, 1996. Medical assistance shall be available to persons who were receiving SSI as of August 22, 1996, and who would continue to be eligible for SSI but for section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193).

75.1(39) Working persons with disabilities.

da. Medical assistance shall be available to all persons who meet all of the following conditions:

(1) They are disabled as determined pursuant to rule 441—75.20(249A), except that being engaged in substantial gainful activity will not preclude a determination of disability.

(2) They are less than 65 years of age.

(3) They are members of families (including families of one) whose income is less than 250 percent of the most recently revised official federal poverty level for the family. Family income shall include gross income of all family members, less supplemental security income program disregards, exemptions, and exclusions, including the earned income disregards. However, income attributable to a social security cost-of-living adjustment shall be included only in determining eligibility based on a subsequently published federal poverty level.

(4) They receive earned income from employment or self-employment or are eligible under paragraph 75.1(39) “c.”

(5) They would be eligible for medical assistance under another coverage group set out in this rule (other than the medically needy coverage groups at subrule 75.1(35)), disregarding all income, up to $10,000 of available resources, and any additional resources held by the disabled individual in a retirement account, a medical savings account, or an assistive technology account. For this purpose, disability shall be determined as under subparagraph 75.1(39)”a”(1) above.

(6) They have paid any premium assessed under paragraph 75.1(39)”b” below.

b. Eligibility for a person whose gross income is greater than 150 percent of the federal poverty level for an individual is conditional upon payment of a premium. Gross income includes all earned and unearned income of the conditionally eligible person, except that income attributable to a social
security cost-of-living adjustment shall be included only in determining premium liability based on a subsequently published federal poverty level. A monthly premium shall be assessed at the time of application and at the annual review. The premium amounts and the federal poverty level increments above 150 percent of the federal poverty level used to assess premiums will be adjusted annually on August 1.

(1) Beginning with the month of application, the monthly premium amount shall be established based on projected average monthly income. The monthly premium established shall not be increased for any reason before the next eligibility review. The premium shall not be reduced due to a change in the federal poverty level but may be reduced or eliminated prospectively before the next eligibility review if a reduction in projected average monthly income is verified.

(2) Eligible persons are required to complete and return Form 470-3118 or 470-3118(S), Medicaid Review, with income information during the twelfth month of the annual enrollment period to determine the premium to be assessed for the next 12-month enrollment period.

(3) Premiums shall be assessed as follows:

<table>
<thead>
<tr>
<th>IF THE INCOME OF THE APPLICANT IS ABOVE:</th>
<th>THE MONTHLY PREMIUM IS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>150% of Federal Poverty Level</td>
<td>$34</td>
</tr>
<tr>
<td>165% of Federal Poverty Level</td>
<td>$47</td>
</tr>
<tr>
<td>180% of Federal Poverty Level</td>
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<tr>
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<td>400% of Federal Poverty Level</td>
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</tr>
<tr>
<td>450% of Federal Poverty Level</td>
<td>$186</td>
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<tr>
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<tr>
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<td>$631</td>
</tr>
<tr>
<td>1480% of Federal Poverty Level</td>
<td>$729</td>
</tr>
</tbody>
</table>

(4) Eligibility is contingent upon the payment of any assessed premiums. Medical assistance eligibility shall not be made effective for a month until the premium assessed for the month is paid. The premium must be paid within three months of the month of coverage or of the month of initial billing, whichever is later, for the person to be eligible for the month.

(5) When the department notifies the applicant of the amount of the premiums, the applicant shall pay any premiums due as follows:

1. The premium for each month is due the fourteenth day of the month the premium is to cover. 

   EXCEPTIONS: The premium for the month of initial billing is due the fourteenth day of the following month; premiums for any months prior to the month of initial billing are due on the fourteenth day of the third month following the month of billing.

2. If the fourteenth day falls on a weekend or a state holiday, payment is due the first working day following the holiday or weekend.

3. When any premium payment due in the month it is to cover is not received by the due date, Medicaid eligibility shall be canceled.
(6) Payments received shall be applied in the following order:

1. To the month in which the payment is received if the premium for the current calendar month is unpaid.
2. To the following month when the payment is received after a billing statement has been issued for the following month.
3. To prior months when a full payment has not been received. Payments shall be applied beginning with the most recent unpaid month before the current calendar month, then the oldest unpaid prior month and forward until all prior months have been paid.
4. When premiums for all months above have been paid, any excess shall be held and applied to any months for which eligibility is subsequently established, as specified in numbered paragraphs “1,” “2,” and “3” above, and then to future months when a premium becomes due.
5. Any excess on an inactive account shall be refunded to the client after two calendar months of inactivity or of a zero premium or upon request from the client.

(7) An individual’s case may be reopened when Medicaid eligibility is canceled for nonpayment of premium. However, the full premium must be received by the department on or before the last day of the month following the month the premium is to cover.

(8) Premiums may be submitted in the form of money orders or personal checks to the address printed on the coupon attached to Form 470-3902, MEPD Billing Statement.

(9) Once an individual is canceled from Medicaid due to nonpayment of premiums, the individual must reapply to establish Medicaid eligibility unless the reopening provisions of this subrule apply.

(10) When a premium due in the month it is to cover is not received by the due date, a notice of decision will be issued to cancel Medicaid. The notice will include reopening provisions that apply if payment is received and appeal rights.

(11) Form 470-3902, MEPD Billing Statement, shall be used for billing and collection.

c. Members in this coverage group who become unable to work due to a change in their medical condition or who lose employment shall remain eligible for a period of six months from the month of the change in their medical condition or loss of employment as long as they intend to return to work and continue to meet all other eligibility criteria under this subrule. Members shall submit Form 470-4856, MEPD Intent to Return to Work, to report on the end of their employment and their intent to return to employment.

d. For purposes of this subrule, the following definitions apply:

“Assistive technology” is the systematic application of technologies, engineering, methodologies, or scientific principles to meet the needs of and address the barriers confronted by individuals with disabilities in areas that include education, rehabilitation, technology devices and assistive technology services.

“Assistive technology accounts” include funds in contracts, savings, trust or other financial accounts, financial instruments or other arrangements with a definite cash value set aside and designated for the purchase, lease or acquisition of assistive technology, assistive technology devices or assistive technology services. Assistive technology accounts must be held separate from other accounts and funds and must be used to purchase, lease or otherwise acquire assistive technology, assistive technology services or assistive technology devices for the working person with a disability when a physician, certified vocational rehabilitation counselor, licensed physical therapist, licensed speech therapist, or licensed occupational therapist has established the medical necessity of the device, technology, or service and determined the technology, device, or service can reasonably be expected to enhance the individual’s employment.

“Assistive technology device” is any item, piece of equipment, product system or component part, whether acquired commercially, modified or customized, that is used to increase, maintain, or improve functional capabilities or address or eliminate architectural, communication, or other barriers confronted by persons with disabilities.

“Assistive technology service” means any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device or other assistive technology. It
includes, but is not limited to, services referred to or described in the Assistive Technology Act of 1998, 29 U.S.C. 3002(4).

“Family,” if the individual is under 18 and unmarried, includes parents living with the individual, siblings under 18 and unmarried living with the individual, and children of the individual who live with the individual. If the individual is 18 years of age or older, or married, “family” includes the individual’s spouse living with the individual and any children living with the individual who are under 18 and unmarried. No other persons shall be considered members of an individual’s family. An individual living alone or with others not listed above shall be considered to be a family of one.

“Medical savings account” means an account exempt from federal income taxation pursuant to Section 220 of the United States Internal Revenue Code (26 U.S.C. § 220).

“Retirement account” means any retirement or pension fund or account, listed in Iowa Code section 627.6(8) “f” as exempt from execution, regardless of the amount of contribution, the interest generated, or the total amount in the fund or account.

75.1(40) People who have been screened and found to need treatment for breast or cervical cancer.

a. Medical assistance shall be available to people who:

(1) Have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act and have been found to need treatment for either breast or cervical cancer (including a precancerous condition);

(2) Do not otherwise have creditable coverage, as that term is defined by the Health Insurance Portability and Accountability Act (HIPAA) (42 U.S.C. Section 300gg(c)(1)), and are not eligible for medical assistance under Iowa Code section 249A.3(1); and

(3) Are under the age of 65.

b. Eligibility established under paragraph “a” continues until the person is:

(1) No longer receiving treatment for breast or cervical cancer;

(2) No longer under the age of 65; or

(3) Covered by creditable coverage or eligible for medical assistance under Iowa Code section 249A.3(1).

c. Presumptive eligibility. A person who has been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act, who has been found to need treatment for either breast or cervical cancer (including a precancerous condition), and who is determined by a qualified provider to be presumptively eligible for medical assistance under paragraph “a” shall be eligible for medical assistance until the last day of the month following the month of the presumptive eligibility determination if no Medicaid application is filed in accordance with rule 441—76.1(249A) by that day or until the date of a decision on a Medicaid application filed in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination, whichever is earlier.

The person shall complete Form 470-2927 or 470-2927(S), Health Services Application, in order for the qualified provider to make the presumptive eligibility determination. Presumptive eligibility shall begin no earlier than the date the qualified Medicaid provider determines eligibility.

Payment of claims for services provided to a person under this paragraph is not dependent upon a finding of Medicaid eligibility for the person.

(1) A provider who is qualified to determine presumptive eligibility is defined as a provider who:

1. Is eligible for payment under the Medicaid program; and

2. Either:

   ● Has been named lead agency for a county or regional local breast and cervical cancer early detection program under a contract with the department of public health; or

   ● Has a cooperative agreement with the department of public health under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act to receive reimbursement for providing breast or cervical cancer
screening or diagnostic services to participants in the Care for Yourself Breast and Cervical Cancer Early Detection Program; and

3. Has made application and has been specifically designated by the department in writing as a qualified provider for the purpose of determining presumptive eligibility under this rule.

(2) The provider shall complete Form 470-3864, Application for Authorization to Make Presumptive Medicaid Eligibility Determinations (BCCT), and submit it to the department for approval in order to be designated as a provider qualified to make presumptive eligibility determinations. Once the department has approved the provider’s application, the provider and the department shall sign Form 470-3865, Memorandum of Understanding with a Qualified Provider for People with Breast or Cervical Cancer Treatment. When both parties have signed the memorandum, the department shall designate the provider as a qualified provider and notify the provider.

(3) When a qualified provider has made a presumptive eligibility determination for a person, the provider shall:
   1. Contact the department to obtain a state identification number for the person who has been determined presumptively eligible.
   2. Notify the department in writing of the determination within five working days after the date the presumptive eligibility determination is made. The provider shall use a copy of Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, for this purpose.
   3. Inform the person in writing, at the time the determination is made, that if the person has not applied for Medicaid on Form 470-2927 or 470-2927(S), Health Services Application, the person has until the last day of the month following the month of the preliminary determination to file the application with the department. The qualified provider shall use Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, for this purpose.
   4. Forward copies of Form 470-2927 or 470-2927(S), Health Services Application, to the appropriate department office for eligibility determination if the person indicated on the application that the person was applying for any of the other programs. The provider shall forward these copies and proof of screening for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program within two working days from the date of the presumptive eligibility determination.
   5. In the event that a person needing care does not appear to be presumptively eligible, the qualified provider shall inform the person that the person may file an application at the county department office if the person wishes to have an eligibility determination made by the department.
   6. Presumptive eligibility shall end under either of the following conditions:
      1. The person fails to file an application for Medicaid in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination.
      2. The person files a Medicaid application by the last day of the month following the month of the presumptive eligibility determination and is found ineligible for Medicaid.
   7. Adequate and timely notice requirements and appeal rights shall apply to an eligibility determination made on a Medicaid application filed pursuant to rule 441—76.1(249A). However, notice requirements and appeal rights of the Medicaid program shall not apply to a person who is:
      1. Denied presumptive eligibility by a qualified provider.
      2. Determined to be presumptively eligible by a qualified provider and whose presumptive eligibility ends because the person fails to file an application by the last day of the month following the month of the presumptive eligibility determination.
   8. A new period of presumptive eligibility shall begin each time a person is screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act, is found to need treatment for breast or cervical cancer, and files Form 470-2927 or 470-2927(S), Health Services Application, with a qualified provider.

75.1(41) Persons eligible for family planning services under demonstration waiver. Rescinded IAB 10/11/17, effective 10/1/17.
75.1(42) Medicaid for independent young adults. Medical assistance shall be available, as assistance related to the family medical assistance program, to a person who left a foster care placement on or after May 1, 2006, and meets all of the following conditions:

a. The person is at least 18 years of age and under 21 years of age.

b. On the person’s eighteenth birthday, the person resided in foster care and Iowa was responsible for the foster care payment pursuant to Iowa Code section 234.35.

c. The person is not a mandatory household member or receiving Medicaid benefits under another coverage group.

d. The person has income below 200 percent of the most recently revised federal poverty level for the person’s household size.

(1) “Household” shall mean the person and any of the following people who are living with the person and are not active on another Medicaid case:

1. The person’s own children;

2. The person’s spouse; and

3. Any children of the person’s spouse who are under the age of 18 and unmarried.

No one else shall be considered a member of the person’s household. A person who lives alone or with others not listed above, including the person’s parents, shall be considered a household of one.

(2) The department shall determine the household’s countable income pursuant to rule 441—75.57(249A). Twenty percent of earned income shall be disregarded.

(3) A person found to be income-eligible upon application or upon annual redetermination of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

75.1(43) Medicaid for children with disabilities. Medical assistance shall be available to children who meet all of the following conditions on or after January 1, 2009:

a. The child is under 19 years of age.

b. The child is disabled as determined pursuant to rule 441—75.20(249A) based on the disability standards for children used for Supplemental Security Income (SSI) benefits under Title XVI of the Social Security Act, but without regard to any income or asset eligibility requirements of the SSI program.

c. The child is enrolled in any group health plan available through the employer of a parent living in the same household as the child if the employer contributes at least 50 percent of the total cost of annual premiums for that coverage. The parent shall enroll the child and pay any employee premium required to maintain coverage for the child.

d. The child’s household has income at or below 300 percent of the federal poverty level applicable to a family of that size.

(1) For this purpose, the child’s household shall include any of the following persons who are living with the child and are not receiving Medicaid on another case:

1. The child’s parents.

2. The child’s siblings under the age of 19.

3. The child’s spouse.

4. The child’s children.

5. The children of the child’s spouse.

(2) Only those persons identified in subparagraph (1) shall be considered a member of the child’s household. A person who receives medically needy coverage with a spenddown or limited benefits such as Medicare savings programs only is not considered to be “receiving Medicaid” for the purposes of subparagraph (1). A child who lives alone or with persons not identified in subparagraph (1) shall be considered as having a household of one.

(3) For this purpose, the income of all persons included in the child’s household shall be determined as provided for SSI-related groups under subrule 75.13(2).

(4) The federal poverty levels used to determine eligibility shall be revised annually on April 1.

75.1(44) Presumptive eligibility for children. Medical assistance shall be available to children under the age of 19 who are determined by a qualified entity to be presumptively eligible for medical assistance pursuant to this subrule.
a. **Qualified entity**. A “qualified entity” is an entity described in paragraphs (1) through (10) of the definition of the term at 42 CFR 435.1101, as amended to October 1, 2008, that:
   
   (1) Has been determined by the department to be capable of making presumptive determinations of eligibility, and
   
   (2) Has signed an agreement with the department as a qualified entity.

b. **Application process**. Families requesting assistance for children under this subrule shall apply with a qualified entity using the form specified in 441—paragraph 76.1(1) “f.” The qualified entity shall use the department’s web-based system to make the presumptive eligibility determination, based on the information provided in the application.

   (1) All presumptive eligibility applications shall be forwarded to the department for a full Medicaid or HAWK-I eligibility determination, regardless of the child’s presumptive eligibility status.
   
   (2) The date a valid application was received by the qualified entity establishes the date of application for purposes of determining the effective date of Medicaid or HAWK-I eligibility unless the qualified entity received the application on a weekend or state holiday. Applications received by the qualified entity on a weekend or a state holiday shall be considered to be received on the first business day following the weekend or state holiday.
   
   (3) The qualified entity shall issue Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, to inform the applicant of the decision on the application as soon as possible but no later than within two working days after the date the determination is made.
   
   (4) Timely and adequate notice requirements and appeal rights of the Medicaid program shall not apply to presumptive eligibility decisions made by a qualified entity.

c. **Eligibility requirements**. To be determined presumptively eligible for medical assistance, a child shall meet the following eligibility requirements.

   (1) Age. The child must be under the age of 19.
   
   (2) Household income. Household income must be less than 300 percent of the federal poverty level for a household of the same size. For this purpose, the household shall include the applicant child and any sibling (of whole or half blood, or adoptive), spouse, parent, or stepparent living with the applicant child. This determination shall be based on the household’s gross income, with no deductions, diversions, or disregards.
   
   (3) Citizenship or qualified alien status. The child must be a citizen of the United States or a qualified alien as defined in subrule 75.11(2).
   
   (4) Iowa residency. The child must be a resident of Iowa.
   
   (5) Prior presumptive eligibility. A child shall not be determined presumptively eligible more than once in a 12-month period. The first month of the 12-month period begins with the month the application is received by the qualified entity.

d. **Period of presumptive eligibility**. Presumptive eligibility shall begin with the date that presumptive eligibility is determined and shall continue until the earliest of the following dates:

   (1) The last day of the next calendar month;
   
   (2) The day the child is determined eligible for Medicaid;
   
   (3) The last day of the month that the child is determined eligible for HAWK-I; or
   
   (4) The day the child is determined ineligible for Medicaid and HAWK-I. Withdrawal of the Medicaid or HAWK-I application before eligibility is determined shall not affect the child’s eligibility during the presumptive period.

e. **Services covered**. Children determined presumptively eligible under this subrule shall be entitled to all Medicaid-covered services, including early and periodic screening, diagnosis, and treatment (EPSDT) services. Payment of claims for Medicaid services provided to a child during the presumptive eligibility period, including EPSDT services, is not dependent upon a determination of Medicaid or HAWK-I eligibility by the department.

75.1(45) **Medicaid for former foster care youth**. Effective January 1, 2014, medical assistance shall be available to a person who meets all of the following conditions:

   a. The person is at least 18 years of age (or such higher age to which foster care is provided to the person) and under 26 years of age;
b. The person is not described in or enrolled under any of Subclauses (I) through (VII) of Section 1902(a)(10)(A)(i) of Title XIX of the Social Security Act or is described in any of such subclauses but has income that exceeds the level of income applicable under Iowa’s state Medicaid plan for eligibility to enroll for medical assistance under such subclause;

c. The person was in foster care under the responsibility of Iowa on the date of attaining 18 years of age or such higher age to which foster care is provided; and

d. The person was enrolled in the Iowa Medicaid program under Title XIX of the Social Security Act while in such foster care.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.6.

441—75.2(249A) Medical resources. Medical resources include health and accident insurance, eligibility for care through the Department of Veterans Affairs, specialized child health services, Title XVIII of the Social Security Act (Medicare), and other resources for meeting the cost of medical care which may be available to the member. These resources must be used when reasonably available.

75.2(1) The department shall approve payment only for those services or that part of the cost of a given service for which no medical resources exist unless pay and chase provisions as defined in rule 441—75.25(249A) are applicable.

a. Persons who have been approved by the Social Security Administration for Supplemental Security Income shall complete Form 470-0364, 470-0364(M), 470-0364(MS), or 470-0364(S), SSI Medicaid Information, and return it to the department.

b. Persons eligible for Part B of the Medicare program shall make assignment to the department on Form 470-0364, 470-0364(M), 470-0364(MS), or 470-0364(S), SSI Medicaid Information.

75.2(2) As a condition of eligibility for medical assistance, a person who has the legal capacity to execute an assignment shall do all of the following:

a. Assign to the department any rights to payments of medical care from any third party to the extent that payment has been made under the medical assistance program. The applicant’s signature on any form listed in 441—subrule 76.1(1) shall constitute agreement to the assignment. The assignment shall be effective for the entire period for which medical assistance is paid.

b. Cooperate with the department in obtaining third-party payments. The member or one acting on the member’s behalf shall:

(1) File a claim or submit an application for any reasonably available medical resource, and

(2) Cooperate in the processing of the claim or application.

c. Cooperate with the department in identifying and providing information to assist the department in pursuing any third party who may be liable to pay for medical care and services available under the medical assistance program.

75.2(3) Good cause for failure to cooperate in the filing or processing of a claim or application shall be considered to exist when the member, or one acting on behalf of a minor, or of a legally incompetent adult member, is physically or mentally incapable of cooperation. Good cause shall be considered to exist when cooperation is reasonably anticipated to result in:

a. Physical or emotional harm to the member for whom medical resources are being sought.

b. Physical or emotional harm to the parent or payee, acting on the behalf of a minor, or of a legally incompetent adult member, for whom medical resources are being sought.

75.2(4) Failure to cooperate as required in subrule 75.2(2) without good cause as defined in subrule 75.2(3) shall result in the termination of medical assistance benefits. The department shall make the
determination of good cause based on information and evidence provided by the member or by one acting on the member’s behalf.

a. The medical assistance benefits of a minor or a legally incompetent adult member shall not be terminated for failure to cooperate in reporting medical resources.

b. When a parent or payee acting on behalf of a minor or legally incompetent adult member fails to file a claim or application for reasonably available medical resources or fails to cooperate in the processing of a claim or application without good cause, the medical assistance benefits of the parent or payee shall be terminated.

This rule is intended to implement Iowa Code sections 249A.4, 249A.5 and 249A.6.

[ARC 7546B, IAB 2/11/09, effective 4/1/09; ARC 8503B, IAB 2/10/10, effective 1/13/10; ARC 8785B, IAB 6/2/10, effective 8/1/10]

441—75.3(249A) Acceptance of other financial benefits. An applicant or member shall take all steps necessary to apply for and, if entitled, accept any income or resources for which the applicant or member may qualify, unless the applicant or member can show an incapacity to do so. Sources of benefits may be, but are not limited to, annuities, pensions, retirement or disability benefits, veterans’ compensation and pensions, old-age, survivors, and disability insurance, railroad retirement benefits, black lung benefits, or unemployment compensation.

75.3(1) When it is determined that the supplemental security income (SSI)-related applicant or member may be entitled to other cash benefits, the department shall send a Notice Regarding Acceptance of Other Benefits, Form 470-0383, to the applicant or member.

75.3(2) The SSI-related applicant or member must express an intent to apply or refuse to apply for other benefits within ten calendar days from the date the notice is issued. A signed refusal to apply or failure to return the form shall result in denial of the application or cancellation of Medicaid unless the applicant or member is mentally or physically incapable of filing the claim for other cash benefits.

75.3(3) When the SSI-related applicant or member is physically or mentally incapable of filing the claim for other cash benefits, the department shall request the person acting on behalf of the member to pursue the potential benefits.

75.3(4) The SSI-related applicant or member shall cooperate in applying for the other benefits. Failure to timely secure the other benefits shall result in cancellation of Medicaid.

EXCEPTION: An applicant or member shall not be required to apply for supplementary security income to receive Medicaid under subrule 75.1(17).

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

441—75.4(249A) Medical assistance lien.

75.4(1) When the medical assistance program pays for a member’s medical care or expenses, the department shall have a lien upon all monetary claims which the member may have against third parties for those expenses. Monetary claims shall include medical malpractice claims for injuries sustained on or after July 1, 2011. The lien shall be to the extent of the medical assistance payments only.

a. A lien is not effective unless the department files a notice of lien with the clerk of the district court in the county where the member resides and with the member’s attorney when the member’s eligibility for medical assistance is established. The notice of lien shall be filed before the third party has concluded a final settlement with the member, the member’s attorney, or other representative.

b. The third party shall obtain a written determination from the department concerning the amount of the lien before a settlement is deemed final.

(1) A compromise, including, but not limited to, notification, settlement, waiver or release of a claim, does not defeat the department’s lien except pursuant to the written agreement of the director or the director’s designee under which the department would receive less than full reimbursement of the amounts it expended.

(2) A settlement, award, or judgment structured in any manner not to include medical expenses or an action brought by a member or on behalf of a member which fails to state a claim for recovery of medical expenses does not defeat the department’s lien if there is any recovery on the member’s claim.
c. All notifications to the department required by law shall be directed to the Iowa Medicaid Enterprise, Revenue Collection Unit, P.O. Box 36475, Des Moines, Iowa 50315. Notification shall be considered made as of the time the notification is deposited so addressed, postage prepaid, in the United States Postal Service system.

75.4(2) The department may pursue its rights to recover either directly from any third party or from any recovery obtained by or on behalf of any member. If a member incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim to which the department has a lien under this section, upon the receipt of the judgment or settlement of the total claim, of which the lien for medical assistance payments is a part, the court costs and reasonable attorney fees shall first be deducted from this total judgment or settlement. One-third of the remaining balance shall then be deducted and paid to the member. From the remaining balance, the lien of the department shall be paid. Any amount remaining shall be paid to the member. An attorney acting on behalf of a member for the purpose of enforcing a claim to which the department has a lien shall not collect from the member any amount as attorney fees which is in excess of the amount which the attorney customarily would collect on claims not subject to this rule. The department will provide computer-generated documents or claim forms describing the services for which it has paid upon request of any affected member or the member’s attorney. The documents may also be provided to a third party where necessary to establish the extent of the department’s claim.

75.4(3) In those cases where appropriate notification is not given to the department or where the department’s recovery rights are otherwise adversely affected by an action of the member or one acting on the member’s behalf, medical assistance benefits shall be terminated. The medical assistance benefits of a minor child or a legally incompetent adult member shall not be terminated. Subsequent eligibility for medical assistance benefits shall be denied until an amount equal to the unrecovered claim has been reimbursed to the department or the individual produces documentation of incurred medical expense equal to the amount of the unrecovered claim. The incurred medical expense shall not be paid by the medical assistance program.

a. The client, or one acting on the client’s behalf, shall provide information and verification as required to establish the availability of medical or third-party resources.


c. The client or person acting on the client’s behalf shall complete Form 470-2826, Supplemental Insurance Questionnaire, in a timely manner at the time of application, when any change in medical resources occurs during the application period, and when any changes in medical resources occur after the application is approved.

A report shall be considered timely when made within ten days from:

1. The date that health insurance begins, changes, or ends.

2. The date that eligibility begins for care through the Department of Veterans Affairs, specialized child health services, Title XVIII of the Social Security Act (Medicare) and other resources.

3. The date the client, or one acting on the client’s behalf, files an insurance claim against an insured third party, for the payment of medical expenses that otherwise would be paid by Medicaid.

4. The date the member, or one acting on the member’s behalf, retains an attorney with the expectation of seeking restitution for injuries from a possibly liable third party, and the medical expenses resulting from those injuries would otherwise be paid by Medicaid.

5. The date that the member, or one acting on the member’s behalf, receives a partial or total settlement for the payment of medical expenses that would otherwise be paid by Medicaid.

The member may report the change in person, by telephone, by mail or by using the Ten-Day Report of Change, Form 470-0499 or 470-0499(S), which is mailed with the Family Investment Program warrants and is issued to the client when Medicaid applications are approved, when annual reviews are completed, when a completed Ten-Day Report of Change is submitted, and when the client requests a form.

d. The member, or one acting on the member’s behalf, shall complete the Priority Leads Letter, Form 470-0398, when the department has reason to believe that the member has sustained
an accident-related injury. Failure to cooperate in completing and returning this form, or in giving complete and accurate information, shall result in the termination of Medicaid benefits.

e. When the recovery rights of the department are adversely affected by the actions of a parent or payee acting on behalf of a minor or legally incompetent adult member, the Medicaid benefits of the parent or payee shall be terminated. When a parent or payee fails to cooperate in completing or returning the Priority Leads Letter, Form 470-0398, or the Supplemental Insurance Questionnaire, Form 470-2826, or fails to give complete and accurate information concerning the accident-related injuries of a minor or legally incompetent adult member, the department shall terminate the Medicaid benefits of the parent or payee.

f. The member, or one acting on the member’s behalf, shall refund to the department from any settlement or payment received the amount of any medical expenses paid by Medicaid. Failure of the member to do so shall result in the termination of Medicaid benefits. In those instances where a parent or payee, acting on behalf of a minor or legally incompetent adult member, fails to refund a settlement overpayment to the department, the Medicaid benefits of the parent or payee shall be terminated.

75.4(4) Third party and provider responsibilities.

a. The health care services provider shall inform the department by appropriate notation on the Health Insurance Claim, Form CMS-1500, that other coverage exists but did not cover the service being billed or that payment was denied.

b. The health care services provider shall notify the department in writing by mailing copies of any billing information sent to a member, an attorney, an insurer or other third party after a claim has been submitted to or paid by the department.

c. An attorney representing an applicant for medical assistance or a past or present Medicaid member on a claim to which the department has filed a lien under this rule shall notify the department of the claim of which the attorney has actual knowledge, before filing a claim, commencing an action or negotiating a settlement offer. Actual knowledge shall include the notice to the attorney pursuant to subrule 75.4(1). The mailing and deposit in a United States post office or public mailing box of the notice, addressed to the department at its state or local office location, is adequate legal notice of the claim.

75.4(5) Department’s lien.

a. The department’s liens are valid and binding on an attorney, insurer or other third party only upon notice by the department or unless the attorney, insurer or other third party has actual notice that the member is receiving medical assistance from the department and only to the extent that the attorney, insurer or third party has not made payment to the member or an assignee of the member prior to the notice.

Any information released to an attorney, insurer or other third party, by the health care services provider, that indicates that reimbursement from the state was contemplated or received, shall be construed as giving the attorney, insurer or other third party actual knowledge of the department’s involvement. For example, information supplied by a health care services provider which indicates medical assistance involvement shall be construed as showing involvement by the department under Iowa Code section 249A.6. Payment of benefits by an insurer or third party pursuant to the rights of the lienholder in this rule discharges the attorney, insurer or other third party from liability to the member or the member’s assignee to the extent of the payment to the department.

b. When the department has reason to believe that an attorney is representing a member on a claim to which the department filed a lien under this rule, the department shall issue notice to that attorney of the department’s lien rights by mailing the Notice of Medical Assistance Lien, Form 470-3030, to the attorney.

c. When the department has reason to believe that an insurer is liable for the costs of a member’s medical expenses, the department shall issue notice to the insurer of the department’s lien rights by mailing the Notice of Medical Assistance Lien, Form 470-3030, to the insurer.

d. The mailing and deposit in a United States post office or public mailing box of the notice, addressed to the attorney or insurer, is adequate legal notice of the department’s subrogation rights.
75.4(6) For purposes of this rule, the term “third party” includes an attorney, individual, institution, corporation, or public or private agency which is or may be liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant for medical assistance or a past or present Medicaid member.

75.4(7) The department may enforce its lien by a civil action against any liable third party.

This rule is intended to implement Iowa Code sections 249A.4, 249A.5, and 249A.6.

[ARC 968B, IAB 9/7/11, effective 9/1/11; ARC 9881B, IAB 11/30/11, effective 1/4/12]

441—75.5(249A) Determination of countable income and resources for persons in a medical institution. In determining eligibility for any coverage group under rule 441—75.1(249A), certain factors must be considered differently for persons who reside in a medical institution. They are:

75.5(1) Determining income from property.

a. Nontrust property. Where there is nontrust property, unless the document providing income specifies differently, income paid in the name of one person shall be available only to that person. 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, including a Medicaid client, a client’s spouse, or both, the income shall be considered in proportion to the Medicaid client’s or spouse’s interest. If payment is made jointly to both spouses and no interest is specified, one-half of the couple’s joint interest shall be considered available for each spouse. If the client or the client’s spouse can establish different ownership by a preponderance of evidence, the income shall be divided in proportion to the ownership.

b. 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.

75.5(2) Division of income between married people for SSI-related coverage groups.

a. Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized person’s income shall be considered in determining eligibility for the institutionalized spouse.

b. Spouses institutionalized and living together. Partners in a marriage who are residing in the same room in a medical institution shall be treated as a couple until the first day of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or receive reduced benefits by considering them separate individuals or if they choose to be considered together. When spouses are treated as a couple, the combined income of the couple shall not exceed twice the amount of the income limit established in subrule 75.1(7). Persons treated together as a couple for income must be treated together for resources and persons treated individually for income must be treated individually for resources.

Spouses residing in the same room in a medical institution may be treated as individuals effective the first day of the seventh calendar month. The income of each spouse shall not exceed the income limit established in subrule 75.1(7).

c. Spouses institutionalized and living apart. Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, shall be treated as individuals effective the month after the month the partners cease living together. Their income shall be treated separately for eligibility. If they live in the same facility after six months of continuous residence, they may be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or receive reduced benefits by considering them separate individuals or if they choose to be considered together.

In the month of entry into a medical institution, income shall not exceed the amount of the income limit established in subrule 75.1(7).

75.5(3) Attribution of resources to institutionalized spouse and community spouse. The department shall determine the attribution of a couple’s resources to the institutionalized spouse and to the community spouse when the institutionalized spouse is expected to remain in a medical institution at
least 30 consecutive days on or after September 30, 1989, at the beginning of the first continuous period of institutionalization.

a. When determined. The department shall determine the attribution of resources between spouses at the earlier of the following:

(1) When either spouse requests that the department determine the attribution of resources at the beginning of the person’s continuous stay in a medical facility prior to an application for Medicaid benefits. This request must be accompanied by Form 470-2577, Resources Upon Entering a Medical Facility, and necessary documentation.

(2) When the institutionalized spouse or someone acting on that person’s behalf applies for Medicaid benefits. If the application is not made in the month of entry, the applicant shall also complete Form 470-2577 and provide necessary documentation.

b. Information required. The couple must provide the social security number of the community spouse. The attribution process shall include a match of the Internal Revenue Service data for both the institutionalized and community spouses.

c. Resources considered. The resources attributed shall include resources owned by both the community spouse and institutionalized spouse except for the following resources:

(1) The home in which the spouse or relatives as defined in 441—paragraph 41.22(3) “a” live (including the land that appertains to the home).

(2) Household goods, personal effects, and one automobile.

(3) The value of any burial spaces held for the purpose of providing a place for the burial of either spouse or any other member of the immediate family.

(4) Other property essential to the means of self-support of either spouse as to warrant its exclusion under the SSI program.

(5) Resources of a blind or disabled person who has a plan for achieving self-support as determined by division of vocational rehabilitation or the department of human services.

(6) For natives of Alaska, shares of stock held in a regional or a village corporation, during the period of 20 years in which the stock is inalienable, as provided in Section 7(h) and Section 8(c) of the Alaska Native Claims Settlement Act.

(7) Assistance under the Disaster Relief Act and Emergency Assistance Act or other assistance provided pursuant to federal statute on account of a presidentially declared major disaster 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.

(8) Any amount of underpayment of SSI or social security benefit due either spouse for one or more months prior to the month of receipt. This exclusion shall be limited to the first six months following receipt.

(9) A life insurance policy(ies) whose total face value is $1500 or less per spouse.

(10) An amount, not in excess of $1500 for each spouse that is separately identifiable and has been set aside to meet the burial and related expenses of that spouse. The amount of $1500 shall be reduced by an amount equal to the total face value of all insurance policies which are owned by the person or spouse and the total of any amounts in an irrevocable trust or other irrevocable arrangement available to meet the burial and related expenses of that spouse.

(11) Federal assistance paid for housing occupied by the spouse.

(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 client 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.

d. Method of attribution. The resources attributed to the institutionalized spouse shall be one-half of the documented resources of both the institutionalized spouse and the community spouse as of the first moment of the first day of the month of the spouse’s first entry to a medical facility. However, if one-half of the resources is less than $24,000, then $24,000 shall be protected for the community
spouse. Also, when one-half of the resources attributed to the community spouse exceeds the maximum amount allowed as a community spouse resource allowance by Section 1924(f)(2)(A)(i) of the Social Security Act (42 U.S.C. § 1396r-5(f)(2)(A)(i)), the amount over the maximum shall be attributed to the institutionalized spouse. (The maximum limit is indexed annually according to the consumer price index.)

If the institutionalized spouse has transferred resources to the community spouse under a court order for the support of the community spouse, the amount transferred shall be the amount attributed to the community spouse if it exceeds the specified limits above.

e. Notice and appeal rights. The department shall provide each spouse a notice of the attribution results. The notice shall state that either spouse has a right to appeal the attribution if the spouse believes:

1. That the attribution is incorrect, or
2. That the amount of income generated by the resources attributed to the community spouse is inadequate to raise the community spouse’s income to the minimum monthly maintenance allowance.

If an attribution has not previously been appealed, either spouse may appeal the attribution upon the denial of an application for Medicaid benefits based on the attribution.

f. Appeals. Hearings on attribution decisions shall be governed by procedures in 441—Chapter 7. If the hearing establishes that the community spouse’s resource allowance is inadequate to raise the community spouse’s income to the minimum monthly maintenance allowance, there shall be substituted an amount adequate to provide the minimum monthly maintenance needs allowance.

1. To establish that the resource allowance is inadequate and receive a substituted allowance, the applicant must provide verification of all the income of the community spouse. For an applicant who became an institutionalized spouse on or after February 8, 2006, all income of the institutionalized spouse that could be made available to the community spouse pursuant to 75.16(2) “d” shall be treated as countable income of the community spouse when the attribution decision was made on or after February 8, 2006.

2. The amount of resources adequate to provide the community spouse minimum maintenance needs allowance shall be based on the cost of a single premium lifetime annuity with monthly payments equal to the difference between the monthly maintenance needs allowance and other countable income not generated by either spouse’s countable resources.

3. The resources necessary to provide the minimum maintenance needs allowance shall be based on the maintenance needs allowance as provided by these rules at the time of the filing of the appeal.

4. To receive the substituted allowance, the applicant shall be required to obtain one estimate of the cost of the annuity.

5. The estimated cost of an annuity shall be substituted for the amount of resources attributed to the community spouse when the amount of resources previously determined is less than the estimated cost of an annuity. If the amount of resources previously attributed for the community spouse is greater than the estimated cost of an annuity, there shall be no substitution for the cost of the annuity, and the attribution will remain as previously determined.

6. The applicant shall not be required to purchase this annuity as a condition of Medicaid eligibility.

7. If the appellant provides a statement from an insurance company that it will not provide an estimate due to the potential annuitant’s age, the amount to be set aside shall be determined using the following calculation: The difference between the community spouse’s gross monthly income not generated by countable resources (times 12) and the minimum monthly maintenance needs allowance (times 12) shall be multiplied by the annuity factor for the age of the community spouse in the Table for an Annuity for Life published at the end of Iowa Code chapter 450. This amount shall be substituted for the amount of resources attributed to the community spouse pursuant to subparagraph 75.5(3) “f”(5).

75.5(4) Consideration of resources of married people.

a. One spouse in a medical facility who entered the facility on or after September 30, 1989.

1. Initial month. When the institutionalized spouse is expected to stay in a medical facility less than 30 consecutive days, the resources of both spouses shall be considered in determining initial Medicaid eligibility.
When the institutionalized spouse is expected to be in a medical facility 30 consecutive days or more, only the resources not attributed to the community spouse according to subrule 75.5(3) shall be considered in determining initial eligibility for the institutionalized spouse.

The amount of resources counted for eligibility for the institutionalized spouse shall be the difference between the couple’s total resources at the time of application and the amount attributed to the community spouse under this rule.

(2) Ongoing eligibility. After the month in which the institutionalized spouse is determined eligible, no resources of the community spouse shall be deemed available to the institutionalized spouse during the continuous period in which the spouse is in an institution. Resources which are owned wholly or in part by the institutionalized spouse and which are not transferred to the community spouse shall be counted in determining ongoing eligibility. The resources of the institutionalized spouse shall not count for ongoing eligibility to the extent that the institutionalized spouse intends to transfer and does transfer the resources to the community spouse within 90 days unless unable to effect the transfer.

(3) Exception based on estrangement. When it is established by a disinterested third-party source that the institutionalized spouse is estranged from the community spouse, Medicaid eligibility will not be denied on the basis of resources when the applicant can demonstrate hardship.

The applicant can demonstrate hardship when the applicant is unable to obtain information about the community spouse’s resources after exploring all legal means.

The applicant can also demonstrate hardship when resources attributed from the community spouse cause the applicant to be ineligible, but the applicant is unable to access these resources after exhausting legal means.

(4) Exception based on assignment of support rights. The institutionalized spouse shall not be ineligible by attribution of resources that are not actually available when:

1. The institutionalized spouse has assigned to the state any rights to support from the community spouse, or
2. The institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment, but the state has the right to bring a support proceeding against a community spouse without an assignment.

b. One spouse in a medical institution prior to September 30, 1989. When one spouse is in the medical institution prior to September 30, 1989, only the resources of the institutionalized spouse shall count for eligibility according to SSI policies the month after the month of entry. In the month of entry, the resources of both spouses are countable toward the couple resource limit.

c. Spouses institutionalized and living together. The combined resources of both partners in a marriage who are residing in the same room in a medical institution shall be subject to the resource limit for a married couple until the first of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for medical assistance effective with the seventh month if one partner would be ineligible for medical assistance or would receive reduced benefits by considering them separately or if they choose to be considered together. Persons treated together as a couple for resources must be treated together for income and persons treated individually for resources must be treated individually for income. Effective the first of the seventh calendar month of continuous residence, they may be treated as individuals, with the resource limit for each spouse the limit for a single person.

d. Spouses institutionalized and living apart. Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, shall be treated as individuals effective the month after the month the partners cease living together. If they live in the same facility after six months of continuous residence, they may be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or would receive reduced benefits by considering them separately or if they choose to be considered together.

In the month of entry into a medical institution, all resources of both spouses shall be combined and shall be subject to the resource limit for a married couple.
75.5(5) Consideration of resources for persons in a medical institution who have purchased and used a qualified or approved long-term care insurance policy pursuant to department of commerce, division of insurance, rules in 191—Chapter 39 or 72.

a. Eligibility. A person may be eligible for medical assistance under this subrule if:

1. The person is the beneficiary of a qualified long-term care insurance policy or is enrolled in a prepaid health care delivery plan that provides long-term care services pursuant to 191—Chapter 39 or 72; and
2. The person is eligible for medical assistance under 75.1(6), 75.1(7), or 75.1(18) except for excess resources; and
3. The excess resources causing ineligibility under the listed coverage groups do not exceed the “asset adjustment” provided in this subrule.

b. Definition. “Asset adjustment” shall mean a $1 disregard of resources for each $1 that has been paid out under the person’s qualified or approved long-term care insurance policy.

c. Estate recovery. An amount equal to the benefits paid out under a member’s qualified or approved long-term care insurance policy will be exempt from recovery from the estate of the member or the member’s spouse for payments made by the medical assistance program on behalf of the member.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4, and 249A.35 and chapter 514H.

[ARC 8443B, IAB 1/13/10, effective 3/1/10]

441—75.6(249A) Entrance fee for continuing care retirement community or life care community. When an individual resides in a continuing care retirement community or life care community that collects an entrance fee on admission, the entrance fee paid shall be considered a resource available to the individual for purposes of determining the individual’s Medicaid eligibility and the amount of benefits to the extent that:

1. The individual has the ability to use the entrance fee, or the contract between the individual and the community provides that the entrance fee may be used to pay for care should the individual’s other resources or income be insufficient to pay for such care;
2. The individual is eligible for a refund of any remaining entrance fee when the individual dies or when the individual terminates the community contract and leaves the community; and
3. The entrance fee does not confer an ownership interest in the community.

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

441—75.7(249A) Furnishing of social security number.

75.7(1) As a condition of eligibility, except as provided by subrule 75.7(2), all social security numbers issued to each individual (including children) for whom Medicaid is sought must be furnished to the department.

75.7(2) The requirement of subrule 75.7(1) does not apply to an individual who:

a. Is not eligible to receive a social security number;

b. Does not have a social security number and may only be issued a social security number for a valid nonwork reason in accordance with 20 CFR § 422.104; or

c. Refuses to obtain a social security number because of a well-established religious objection. For this purpose, a well-established religious objection means that the individual:

1. Is a member of a recognized religious sect or division of the sect; and

2. Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

75.7(3) If a social security number has not been issued or is not known, the individual seeking Medicaid must cooperate with the department in applying for a social security number with the Social Security Administration or in requesting the Social Security Administration to furnish the number.

[ARC 1134C, IAB 10/30/13, effective 10/2/13]

441—75.8(249A) Medical assistance corrective payments. If a decision by the department or the Social Security Administration following an appeal on a denied application for any of the categories
of medical assistance eligibility set forth in rule 441—75.1(249A) is favorable to the claimant, reimbursement will be made to the claimant for any medical bills paid by the claimant during the period between the date of the denial on the initial application and the date regular medical assistance coverage began when the bills were for medical services rendered in the period now determined to be an eligible period based on the following conditions:

75.8(1) These bills must be for services covered by the medical assistance program as set forth in 441—Chapter 78.

75.8(2) Reimbursement will be based on Medicaid rates for services in effect at the time the services were provided.

75.8(3) If a county relief agency has paid medical bills on the recipient’s behalf and has not received reimbursement through assignment as set forth in 441—Chapter 80, the department will reimburse the county relief agency directly on the same basis as if the reimbursement was made to the recipient.

75.8(4) Recipients and county relief agencies shall file claims for payment under this subrule by submitting Form 470-2224, Verification of Paid Medical Bills, to the department. A supply of these forms is available from the county office. All requests for reimbursement shall be acted upon within 60 days of receipt of all Forms 470-2224 in the county office.

75.8(5) Any adverse action taken by the department with respect to an application for reimbursement is appealable under 441—Chapter 7.

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

441—75.9(249A) Treatment of Medicaid qualifying trusts.

75.9(1) A Medicaid qualifying trust is a trust or similar legal device established, on or before August 10, 1993, other than by will by a person or that person’s spouse under which the person may be the beneficiary of payments from the trust and the distribution of these payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the person. Trusts or initial trust decrees established prior to April 7, 1986, solely for the benefit of a mentally retarded person who resides in an intermediate care facility for the mentally retarded, are exempt.

75.9(2) The amount of income and principal from a Medicaid qualifying trust that shall be considered available shall be the maximum amount that may be permitted under the terms of the trust assuming the full exercise of discretion by the trustee or trustees for the distribution of the funds.

a. Trust income considered available shall be counted as income.

b. Trust principal (including accumulated income) considered available shall be counted as a resource, except where the trust explicitly limits the amount of principal that can be made available on an annual or less frequent basis. Where the trust limits the amount, the principal considered available over any particular period of time shall be counted as income for that period of time.

c. To the extent that the trust principal and income is available only for medical care, this principal or income shall not be used to determine eligibility. To the extent that the trust is restricted to medical expenses, it shall be used as a third party resource.

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

441—75.10(249A) Residency requirements. Residency in Iowa is a condition of eligibility for medical assistance.

75.10(1) Definitions.

a. Institutions. For purposes of this rule, “institution” means an “institution” or a “medical institution” as those terms are defined in 42 CFR § 435.1010 as amended to July 13, 2007. For purposes of state placement, “institution” also includes foster care homes licensed as set forth in 45 CFR § 1355.20 as amended to January 6, 2012, and providing food, shelter and supportive services to one or more persons unrelated to the proprietor.

b. Incapable of expressing intent regarding residency. For purposes of this rule, an individual is considered to be “incapable of indicating intent regarding residency” if the individual:

1. Has an IQ of 49 or less or has a mental age of seven or less;

2. Has been judged legally incompetent; or
3. Has been determined to be incapable of indicating intent regarding residency by a physician, psychologist or other person licensed by the state in the field of intellectual disability.

**75.10(2) Determination of residence.** State residency is determined according to the following criteria. If more than one criterion applies, the applicable criterion listed first determines the individual’s residency:

   a. Cases of disputed residency. If two or more states do not agree on an individual’s state of residence, the state where the individual is physically located is the state of residence.

   b. Temporary absence from state of residence. An individual who was a resident of a state pursuant to the other criteria of this rule, who is temporarily absent from that state, and who intends to return to that state when the purpose of the absence has been accomplished remains a resident of that state during the absence, unless another state has determined that the person is a resident there for Medicaid purposes.

   c. Individuals placed by a state in an out-of-state institution. If any agency of a state, including an entity recognized under state law as being under contract with the state for such purposes, arranges for an individual to be placed in an institution located in another state, the state arranging or actually making the placement is considered the individual’s state of residence during that placement.

   (1) Any action beyond providing information to the individual and the individual’s family constitutes arranging or making a placement. However, the following actions do not constitute arranging or making a placement:

      1. Providing basic information to individuals about another state’s Medicaid program and information about the availability of health care services and facilities in another state.

      2. Assisting an individual in locating an institution in another state, provided the individual is not incapable of indicating intent regarding residency and independently decides to move.

   (2) When a competent individual leaves an out-of-state institution in which the individual was placed by a state, that individual’s state of residence is the state where the individual is physically located.

   d. Individuals receiving a state supplementary assistance payment. Individuals who are receiving a state supplementary assistance payment pursuant to 42 U.S.C. § 1382e (including payments from Iowa pursuant to rules 441—50.1(249) through 441—54.8(249), 441—81.23(249A), 441—82.19(249A), 441—85.47(249A), or 441—177.1(249) through 441—177.11(249)) are considered to be residents of the state paying the supplementary assistance.

   e. Individuals receiving Title IV-E payments. Individuals who are receiving federal foster care or adoption assistance payments for a child under Title IV-E of the Social Security Act are considered to be residents of the state where the child lives.

   f. Individuals aged 21 and over who are residing in an institution and who are capable of indicating intent regarding residency. For an individual aged 21 or over who is residing in an institution and who is not incapable of indicating intent regarding residency, the state of residence is the state where the individual is living and intends to reside.

   g. Individuals aged 21 and over who are residing in an institution and who became incapable of indicating intent regarding residency before the age of 21. For an individual aged 21 or over who is residing in an institution and who became incapable of indicating intent regarding residency before the age of 21, the state of residence is:

      (1) That of the parent applying for Medicaid on the individual’s behalf if the parents reside in separate states (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);

      (2) The parent’s or legal guardian’s state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);

      (3) The current state of residence of the parent or legal guardian who files the application if the individual is residing in an institution in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent); or

      (4) The state of residence of the individual or party who files an application if the individual has been abandoned by the individual’s parent(s), does not have a legal guardian, and is residing in an institution in that state.
h. Individuals aged 21 and over who are residing in an institution and who became incapable of indicating intent regarding residency at or after the age of 21. For an individual aged 21 or over who is residing in an institution and who became incapable of indicating intent regarding residency at or after the age of 21, the state of residence is the state in which the individual is physically present.

i. Individuals aged 21 and over who are not residing in an institution and who are incapable of indicating intent regarding residency. For an individual aged 21 or over who is not residing in an institution and who is incapable of indicating intent regarding residency, the state of residence is the state where the individual is living.

j. Individuals aged 21 and over who are not residing in an institution and who are capable of indicating intent regarding residency. For an individual aged 21 or over who is not residing in an institution and who is not incapable of indicating intent regarding residency, the state of residence is the state where the individual is living and either:

   (1) Intends to reside, with or without a fixed address; or
   (2) Entered with a job commitment or to seek employment, whether or not currently employed.

k. Individuals under the age of 21 who are residing in an institution and who are not married or emancipated. For an individual under the age of 21 who is residing in an institution and who is neither married nor emancipated, the state of residence is:

   (1) The parent’s or legal guardian’s state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);
   (2) The current state of residence of the parent or legal guardian who files the application if the individual is residing in an institution in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent); or
   (3) The state of residence of the individual or party who files an application if the individual has been abandoned by the individual’s parent(s), does not have a legal guardian, and is residing in an institution in that state.

l. Individuals under the age of 21 who are capable of indicating intent regarding residency and who are married or emancipated. For an individual under the age of 21 who is not incapable of indicating intent regarding residency and who is married or emancipated from the individual’s parent, the state of residence is determined in accordance with paragraph 75.10(2) “j.”

m. Other individuals under the age of 21. For an individual under the age of 21 who is not described in paragraph 75.10(2) “k” or “l,” the state of residence is:

   (1) The state where the individual resides, with or without a fixed address; or
   (2) The state of residency of the parent or caretaker, determined in accordance with paragraph 75.10(2) “j,” with whom the individual resides.

This rule is intended to implement Iowa Code section 249A.3.

[ARC 1134C, IAB 10/30/13, effective 10/2/13]

441—75.11(249A) Citizenship or alienage requirements.

75.11(1) Definitions.

“Care and services necessary for the treatment of an emergency medical condition” means services provided in a hospital, clinic, office or other facility that is equipped to furnish the required care for an emergency medical condition, provided the care and services are not related to an organ transplant procedure furnished on or after August 10, 1993. Payment for emergency medical services shall be limited to the day treatment is initiated for the emergency medical condition and the following two days.

“Emergency medical condition” means a medical condition of sudden onset (including labor and delivery) 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 one or more of the following:

1. Placing the patient’s health in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.
“Federal means-tested program” means all federal programs that are means-tested with the exception of:

1. Medical assistance for care and services necessary for the treatment of an emergency medical condition not related to an organ transplant procedure furnished on or after August 10, 1993.
2. Short-term, non-cash, in-kind emergency disaster relief.
3. Assistance or benefits under the National School Lunch Act.
5. Public health assistance (not including any assistance under Title XIX of the Social Security Act) for immunizations with respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases whether or not the symptoms are caused by a communicable disease.
6. Payments of foster care and adoption assistance under Parts B and E of Title IV of the Social Security Act for a parent or a child who would, in the absence of numbered paragraph “1,” be eligible to have payments made on the child’s behalf under such part, but only if the foster or adoptive parent (or parents) of the child is a qualified alien (as defined in Section 431).
7. Programs, services, or assistance (such as soup kitchens, crisis counseling and intervention, and short-term shelter) specified by the attorney general of the United States in the attorney general’s sole and unreviewable discretion after consultation with appropriate federal agencies and departments, that:
   ● Deliver in-kind services at the community level, including through public or private nonprofit agencies;
   ● Do not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the individual recipient’s income or resources; and
   ● Are necessary for the protection of life or safety.
11. Benefits funded through an employment and training program of the U.S. Department of Labor.

“Qualified alien” means an alien:

1. Who is lawfully admitted for permanent residence in the United States under the Immigration and Nationality Act (INA);
2. Who is granted asylum in the United States under Section 208 of the INA;
3. Who is a refugee admitted to the United States under Section 207 of the INA;
4. Who is paroled into the United States under Section 212(d)(5) of the INA for a period of at least one year;
5. Whose deportation from the United States is withheld under Section 243(h) of the INA as in effect before April 1, 1997, or under Section 241(b)(3) of the INA as amended to December 20, 2010;
6. Who is granted conditional entry to the United States pursuant to Section 203(a)(7) of the INA as in effect before April 1, 1980;
7. Who is an Amerasian admitted to the United States as described in 8 U.S.C. Section 1612(b)(2)(A)(i)(V);
8. Who is a Cuban/Haitian entrant to the United States as described in 8 U.S.C. Section 1641(b)(7);
9. Who is a battered alien as described in 8 U.S.C. Section 1641(c);
10. Who is certified as a victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 20, 2010;
11. Who is an American Indian born in Canada to whom Section 289 of the INA applies or is a member of a federally recognized Indian Tribe as defined in 25 U.S.C. Section 450b(e); or
12. Who is under the age of 21 and is lawfully residing in the United States as allowed by 42 U.S.C. Section 1396b(v)(4)(A)(ii).

“Qualifying quarters” includes all of the qualifying quarters of coverage as defined under Title II of the Social Security Act worked by a parent of an alien while the alien was under age 18 and all of the qualifying quarters worked by a spouse of the alien during their marriage if the alien remains married to the spouse or the spouse is deceased. No qualifying quarter of coverage that is creditable under Title II
of the Social Security Act for any period beginning after December 31, 1996, may be credited to an alien if the parent or spouse of the alien received any federal means-tested public benefit during the period for which the qualifying quarter is so credited.

75.11(2) Citizenship and alienage.

a. To be eligible for Medicaid, a person must be one of the following:
   (1) A citizen or national of the United States.
   (2) A qualified alien residing in the United States before August 22, 1996.
   (3) A qualified alien under the age of 21.
   (4) A refugee admitted to the United States under Section 207 of the Immigration and Nationality Act (INA).
   (5) An alien who has been granted asylum under Section 208 of the INA.
   (6) An alien whose deportation is withheld under Section 243(h) or Section 241(b)(3) of the INA.
   (7) A qualified alien veteran who has an honorable discharge that is not due to alienage.
   (8) A qualified alien who is on active duty in the Armed Forces of the United States other than active duty for training.
   (9) A qualified alien who is the spouse or unmarried dependent child of a qualified alien described in subparagraph (7) or (8), including a surviving spouse who has not remarried.
   (10) A qualified alien who has resided in the United States for a period of at least five years.
   (12) A Cuban/Haitian entrant as described in 8 U.S.C. Section 1641(b)(7).
   (13) A certified victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 20, 2010.
   (14) An American Indian born in Canada to whom Section 289 of the INA applies or who is a member of a federally recognized Indian Tribe as defined in 25 U.S.C. Section 450b(e).
   (15) An Iraqi or Afghan immigrant treated as a refugee pursuant to Section 1244(g) of Public Law 110-181 as amended to December 20, 2010, or to Section 602(b)(8) of Public Law 111-8 as amended to December 20, 2010.

b. As a condition of eligibility, each member shall complete and sign Form 470-2549, Statement of Citizenship Status, attesting to the member’s citizenship or alien status. When the member is incompetent or deceased, the form shall be signed by someone acting responsibly on the member’s behalf. An adult shall sign the form for dependent children.

   (1) As a condition of eligibility, all applicants for Medicaid shall attest to their citizenship or alien status by signing the application form which contains the same declaration.

   (2) As a condition of continued eligibility, SSI-related Medicaid members not actually receiving SSI who have been continuous members since August 1, 1988, shall attest to their citizenship or alien status by signing the application form which contains a similar declaration at time of review.

   (3) An attestation of citizenship or alien status completed on any one of the following forms shall meet the requirements of subrule 75.11(2) for children under the age of 19 who are otherwise eligible pursuant to 441—subrule 76.1(8):
      1. Application for Food Assistance, Form 470-0306 or 470-0307 (Spanish);
      2. Health and Financial Support Application, Form 470-0462 or 470-0462(S); or
      3. Review/Recertification Eligibility Document, Form 470-2881, 470-2881(S), 470-2881(M), or 470-2881(MS).

   c. Except as provided in paragraph “f,” applicants or members for whom an attestation of United States citizenship has been made pursuant to paragraph “b” shall present satisfactory documentation of citizenship or nationality as defined in paragraph “d,” “e,” or “i.” A reference to a form in paragraph “d” or “e” includes any successor form. An applicant or member shall have a reasonable period to obtain and provide required documentation of citizenship or nationality.

   (1) For the purposes of this requirement, the “reasonable period” begins on the date a written request for documentation or a notice pursuant to subparagraph 75.11(2) “i”(2) is issued to an applicant or member, whichever is later, and continues for 90 days.
(2) Medicaid shall be approved for new applicants and continue for members not previously required to provide documentation of citizenship or nationality until the end of the reasonable period to obtain and provide required documentation of citizenship or nationality. However, the receipt of Medicaid or HAWK-I benefits pending documentation of citizenship or nationality is limited to one reasonable period of up to 90 days under either program for each individual. An applicant or member who has already received benefits during any portion of a reasonable period shall not be granted coverage for a second reasonable period except as required to protect the confidentiality of an individual who received only limited Medicaid benefits provided pursuant to subrule 75.1(41) during the first period.

(3) Retroactive eligibility pursuant to 441—subrule 76.13(3) is available only after documentation of citizenship or nationality has been provided pursuant to paragraph 75.11(2) “d,” “e,” or “f.” The retroactive months are outside the “reasonable period” during which Medicaid coverage may be provided without required documentation of citizenship or nationality.

(d) Any one of the following documents shall be accepted as satisfactory documentation of citizenship or nationality:

(1) A United States passport.

(2) Form N-550 or N-570 (Certificate of Naturalization) issued by the U.S. Citizenship and Immigration Services.

(3) Form N-560 or N-561 (Certificate of United States Citizenship) issued by the U.S. Citizenship and Immigration Services.

(4) A valid state-issued driver’s license or other identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act, but only if the state issuing the license or document either:

1. Requires proof of United States citizenship before issuance of the license or document; or
2. Obtains a social security number from the applicant and verifies before certification that the number is valid and is assigned to the applicant who is a citizen.

(5) Documentation issued by a federally recognized Indian Tribe showing membership or enrollment in or affiliation with that Tribe.

(6) Another document that provides proof of United States citizenship or nationality and provides a reliable means of documentation of personal identity, as the Secretary of the U.S. Department of Health and Human Services may specify by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(B)(v).

e. Satisfactory documentation of citizenship or nationality may also be demonstrated by the combination of:

(1) Any identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act or any other documentation of personal identity that provides a reliable means of identification, as the secretary of the U.S. Department of Health and Human Services finds by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(D)(ii), and

(2) Any one of the following:


2. Form FS-545 or Form DS-1350 (Certification of Birth Abroad) issued by the U.S. Citizenship and Immigration Services.


5. Another document that provides proof of United States citizenship or nationality, as the secretary of the U.S. Department of Health and Human Services may specify pursuant to 42 U.S.C. Section 1396b(x)(3)(C)(v).

f. A person for whom an attestation of United States citizenship has been made pursuant to paragraph “b” is not required to present documentation of citizenship or nationality for Medicaid eligibility if any of the following circumstances apply:
(1) The person is entitled to or enrolled for benefits under any part of Title XVIII of the federal Social Security Act (Medicare).

(2) The person is receiving federal social security disability insurance (SSDI) benefits under Title II of the federal Social Security Act, Section 223 or 202, based on disability (as defined in Section 223(d)).

(3) The person is receiving supplemental security income (SSI) benefits under Title XVI of the federal Social Security Act.

(4) The person is a child in foster care who is assisted by child welfare services funded under Part B of Title IV of the federal Social Security Act.

(5) The person is receiving foster care maintenance or adoption assistance payments funded under Part E of Title IV of the federal Social Security Act.

(6) The person has previously presented satisfactory documentary evidence of citizenship or nationality, as specified by the United States Secretary of Health and Human Services.

(7) The person is or was eligible for medical assistance pursuant to 42 U.S.C. Section 1396a(e)(4) as the newborn of a Medicaid-eligible mother.

(8) The person is or was eligible for medical assistance pursuant to 42 U.S.C. Section 1397l(e) as the newborn of a mother eligible for assistance under a State Children’s Health Insurance Program (SCHIP) pursuant to Title XXI of the Social Security Act.

g. If no other identity documentation allowed by subparagraph 75.11(2) “e” (1) is available, identity may be documented by affidavit as described in this paragraph. However, affidavits cannot be used to document both identity and citizenship.

(1) For children under the age of 16, identity may be documented using Form 470-4386 or 470-4386(S), Affidavit of Identity, signed by the child’s parent, guardian, or caretaker relative under penalty of perjury.

(2) For disabled persons who live in a residential care facility, identity may be documented using Form 470-4386 or 470-4386(S), Affidavit of Identity, signed by a residential care facility director or administrator under penalty of perjury.

h. If no other documentation that provides proof of United States citizenship or nationality allowed by subparagraph 75.11(2) “e” (2) is available, United States citizenship or nationality may be documented using Form 470-4373 or 470-4373(S), Affidavit of Citizenship. However, affidavits cannot be used to document both identity and citizenship.

(1) Two affidavits of citizenship are required. The person who signs the affidavit must provide proof of citizenship and identity. A person who is not related to the applicant or member must sign at least one of the affidavits.

(2) When affidavits of citizenship are used, Form 470-4374 or 470-4374(S), Affidavit Concerning Documentation of Citizenship, or an equivalent affidavit explaining why other evidence of citizenship does not exist or cannot be obtained must also be submitted and must be signed by the applicant or member or by another knowledgeable person (guardian or representative).

i. In lieu of a document listed in paragraph “d” or “e,” satisfactory documentation of citizenship or nationality may also be presented pursuant to this paragraph.

(1) Provision of an individual’s name, social security number, and date of birth to the department shall constitute satisfactory documentation of citizenship and identity if submission of the name, social security number, and date of birth to the Social Security Administration produces a response that substantiates the individual’s citizenship.

(2) If submission of the name, social security number, and date of birth to the Social Security Administration does not produce a response that substantiates the individual’s citizenship, the department shall issue a written notice to the applicant or member giving the applicant or member 90 days to correct any errors in the name, social security number, or date of birth submitted, to correct any errors in the Social Security Administration’s records, or to provide other documentation of citizenship or nationality pursuant to paragraph “d” or “e.”

75.11(3) *Deeming of sponsor’s income and resources.*

a. When an alien admitted for lawful permanent residence is sponsored by a person who executed an affidavit of support as described in 8 U.S.C. Section 1631(a)(1) on behalf of the alien, the income
and resources of the alien shall be deemed to include the income and resources of the sponsor (and of the sponsor’s spouse if living with the sponsor). The amount deemed to the sponsored alien shall be the total gross countable income and resources of the sponsor and the sponsor’s spouse for the FMAP-related or SSI-related coverage group applicable to the sponsored alien’s household as described in 441—75.13(249A) less the following deductions:

1. For FMAP-related coverage groups: The same income deductions, diversions, and disregards allowed for stepparent cases as described at 75.57(8) “b” and a $1,500 resource deduction.
2. For SSI-related coverage groups: The deductions described at 20 CFR 416.1166a and 416.1204, as amended to April 1, 2010.

b. An indigent alien is exempt from the deeming of a sponsor’s income and resources for 12 months after indigence is determined. An alien shall be considered indigent if the following are true:

1. The alien does not live with the sponsor; and
2. The alien’s gross income, including any income actually received from or made available by the sponsor, is less than 100 percent of the federal poverty level for the sponsored alien’s household size.

c. A battered alien as described in 8 U.S.C. Section 1641(c) is exempt from the deeming of a sponsor’s income and resources for 12 months.

d. Deeming of the sponsor’s income and resources does not apply when:

1. The sponsored alien attains citizenship through naturalization pursuant to Chapter 2 of Title II of the Immigration and Nationality Act.
2. The sponsored alien has earned 40 qualifying quarters of coverage as defined in Title II of the Social Security Act or can be credited with 40 qualifying quarters as defined at subrule 75.11(1).
3. The sponsored alien or the sponsor dies.
4. The sponsored alien is a child under age 21.
5. For SSI-related Medicaid, the sponsored alien becomes blind or disabled as defined under Title XVI of the Social Security Act after admission to the United States as a lawful permanent resident.
6. For SSI-related Medicaid, three years after the date the sponsored alien was admitted to the United States as a lawful permanent resident.

75.11(4) Eligibility for payment of emergency medical services. Aliens who do not meet the provisions of subrule 75.11(2) and who would otherwise qualify except for their alien status are eligible to receive Medicaid for care and services necessary for the treatment of an emergency medical condition as defined in subrule 75.11(1). To qualify for payment under this provision:

a. The alien must meet all other eligibility criteria, including state residence requirements provided at rules 441—75.10(249A) and 441—75.53(249A), with the exception of rule 441—75.7(249A) and subrules 75.11(2) and 75.11(3).

b. The medical provider who treated the emergency medical condition or the provider’s designee must submit verification of the existence of the emergency medical condition on either:

1. Form 470-4299, Verification of Emergency Health Care Services; or
2. A signed statement that contains the same information as requested by Form 470-4299.

This rule is intended to implement Iowa Code section 249A.3.

[ARC 7932B, IAB 7/1/09, effective 7/1/09; ARC 8096B, IAB 9/9/09, effective 10/14/09; ARC 8642B, IAB 4/7/10, effective 6/1/10; ARC 8786B, IAB 6/2/10, effective 6/1/10; ARC 9439B, IAB 4/6/11, effective 6/1/11; ARC 3353C, IAB 10/11/17, effective 10/1/17; ARC 3549C, IAB 1/3/18, effective 2/7/18]

441—75.12(249A) Inmates of public institutions. A person is not eligible for medical assistance for any care or services received while the person is an inmate of a public institution. For the purpose of this rule, “inmate of a public institution” and “public institution” are defined by 42 CFR Section 435.1010 as amended to August 25, 2011.

75.12(1) Suspension. Medical assistance shall be suspended, rather than canceled, for the first 12 continuous calendar months that a person is an inmate of a public institution if all of the following conditions are met:

a. The department is notified of the person’s entry into the public institution through either:
(1) A monthly report which is provided to the department by the public institution and includes the person’s name, date of birth, and social security number and the date the person entered the institution; or

(2) Other verified notice received by the department.
   b. The person has entered a public institution on or after January 1, 2012, and has been in the public institution for 30 days or more.
   c. On the date of entry into the public institution, the person was a Medicaid member.
   d. The person is eligible for medical assistance as an individual except for institutional status.

75.12(2) Coverage during suspension. While medical assistance is suspended, payment will be made only for services received while the person is not an inmate of a public institution.

75.12(3) Reinstatement. The Medicaid case for an inmate who is released from a public institution while Medicaid is suspended will be reopened without an application if both of the following conditions are met:
   a. The department is notified of the person’s release from the public institution through either:
      1) A monthly report which is provided to the department by the public institution and includes the person’s name, date of birth, and social security number and the date the person was released from the institution; or
      2) Other verified notice received by the department.
   b. All information available to the department indicates that the person is currently eligible for Iowa Medicaid as an individual.

This rule is intended to implement Iowa Code section 249A.3 and 2011 Iowa Acts, Senate File 482, division IX.

[ARC 9957B, IAB 1/11/12, effective 1/1/12]

441—75.13(249A) Categorical relatedness.

75.13(1) FMAP-related Medicaid eligibility. Medicaid eligibility for persons who are under the age of 21, pregnant women, or specified relatives of dependent children who are not blind or disabled shall be determined using the income criteria in effect for the family medical assistance program (FMAP) as provided in subrule 75.1(14) unless otherwise specified. Income shall be considered prospectively.

75.13(2) SSI-related Medicaid. Except as otherwise provided in 441—Chapters 75 and 76, persons who are 65 years of age or older, blind, or disabled are eligible for Medicaid only if eligible for the Supplemental Security Income (SSI) program administered by the United States Social Security Administration.

a. SSI policy reference. The statutes, regulations, and policy governing eligibility for SSI are found in Title XVI of the Social Security Act (42 U.S.C. Sections 1381 to 1383f), in the federal regulations promulgated pursuant to Title XVI (20 CFR 416.101 to 416.2227), and in Part 5 of the Program Operations Manual System published by the United States Social Security Administration. The Program Operations Manual System is available at Social Security Administration offices in Ames, Burlington, Carroll, Cedar Rapids, Clinton, Council Bluffs, Creston, Davenport, Decorah, Des Moines, Dubuque, Fort Dodge, Iowa City, Marshalltown, Mason City, Oskaloosa, Ottumwa, Sioux City, Spencer, Storm Lake, and Waterloo, or through the Department of Human Services, Division of Financial, Health, and Work Supports, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

b. Income considered. For SSI-related Medicaid eligibility purposes, income shall be considered prospectively.

c. Trust contributions. Income that a person contributes to a trust as specified at 75.24(3) “b” shall not be considered for purposes of determining eligibility for SSI-related Medicaid.

d. Conditional eligibility. For purposes of determining eligibility for SSI-related Medicaid, the SSI conditional eligibility process, by which a client may receive SSI benefits while attempting to sell excess resources, found at 20 CFR 416.1240 to 416.1245, is not considered an eligibility methodology.

e. Valuation of life estates and remainder interests. In the absence of other evidence, the value of a life estate or remainder interest in property shall be determined using the following table by
multiplying the fair market value of the entire underlying property (including all life estates and all remainder interests) by the life estate or remainder interest decimal corresponding to the age of the life estate holder or other person whose life controls the life estate.

If a Medicaid applicant or recipient disputes the value determined using the following table, the applicant or recipient may submit other evidence and the value of the life estate or remainder interest shall be determined based on the preponderance of all the evidence submitted to or obtained by the department, including the value given by the following table.

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75.13(3) Resource eligibility for SSI-related Medicaid for children. Resources of all household members shall be disregarded when determining eligibility for children under any SSI-related coverage group except for those groups at subrules 75.1(3), 75.1(4), 75.1(6), 75.1(9), 75.1(10), 75.1(12), 75.1(13), 75.1(23), 75.1(25), 75.1(29), 75.1(33), 75.1(34), 75.1(36), 75.1(37), and 75.1(38).

This rule is intended to implement Iowa Code section 249A.3.

441—75.14(249A) Establishing paternity and obtaining support.

75.14(1) As a condition of eligibility, adult Medicaid applicants and members in households with an absent parent shall cooperate in obtaining medical support for themselves and for any other person in the household for whom Medicaid is requested and for whom an applicant or member can legally assign rights for medical support, except when the applicant or member has good cause for refusal to cooperate as defined in subrule 75.14(8).

a. The adult applicant or member shall cooperate in the following:

(1) Identifying and locating the parent of the child for whom Medicaid is requested.

(2) Establishing the paternity of a child born out of wedlock for whom Medicaid is requested.

(3) Obtaining medical support and payments for medical care for the applicant or member and for a child for whom Medicaid is requested.

(4) Rescinded IAB 2/3/93, effective 4/1/93.

b. Cooperation is defined as including the following actions by the adult applicant or member upon request:

(1) Appearing at the income maintenance unit or the child support recovery unit to provide verbal or written information or documentary evidence known to, possessed by or reasonably obtainable by the applicant or member that is relevant to achieving the objectives of the child support recovery program.

(2) Appearing as a witness at judicial or other hearings or proceedings.

(3) Providing information, or attesting to the lack of information, under penalty of perjury.

c. Upon request, the adult applicant or member shall cooperate with the department in supplying information with respect to the absent parent, the receipt of medical support or payments for medical care, and the establishment of paternity, to the extent necessary to establish eligibility for assistance and permit an appropriate referral to the child support recovery unit.

d. Upon request, the adult applicant or member shall cooperate with the child support recovery unit to the extent of supplying all known information and documents pertaining to the location of the absent parent and taking action as may be necessary to secure medical support and payments for medical care or to establish paternity. This includes completing and signing documents determined to be necessary by the state’s attorney for any relevant judicial or administrative process.

e. The child support recovery unit shall make the determination of whether or not the adult applicant or member has cooperated for the purposes of this rule.

75.14(2) Failure of an adult applicant or member to cooperate shall result in denial or cancellation of the noncooperating adult’s Medicaid benefits. In family medical assistance program (FMAP)-related Medicaid cases, all deductions and disregards described at paragraphs 75.57(2)”a,” “b,” and “c” shall be allowed when otherwise applicable.

75.14(3) Each Medicaid applicant or member who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing medical support and payments for medical care. The provisions set forth in subrules 75.14(8) to 75.14(12) shall be used when making a determination of the existence of good cause.

75.14(4) Each Medicaid applicant or member shall assign to the department any rights to medical support and payments for medical care from any other person for which the person can legally make assignment. This shall include rights to medical support and payments for medical care on the applicant’s or member’s own behalf or on behalf of any other family member for whom the applicant or member is applying. An assignment is effective the same date the eligibility information is entered into the automated benefit calculation system and is effective for the entire period for which eligibility is granted. Support payments not intended for medical support shall not be assigned to the department.

75.14(5) Rescinded IAB 6/2/10, effective 8/1/10.
75.14(6) Pregnant women establishing eligibility under the mothers and children (MAC) coverage group as provided at subrule 75.1(28) shall be exempt from the provisions in this rule for any born child for whom the pregnant woman applies for or receives Medicaid. Additionally, any previously pregnant woman eligible for postpartum coverage under the provision of subrule 75.1(24) shall not be subject to the provisions in this rule until after the end of the month in which the 60-day postpartum period expires. Pregnant women establishing eligibility under any other coverage groups except those set forth in subrule 75.1(24) or 75.1(28) shall be subject to the provisions in this rule when establishing eligibility for born children. However, when a pregnant woman who is subject to these provisions fails to cooperate, the woman shall lose eligibility under her current coverage group and her eligibility for Medicaid shall be automatically redetermined under subrule 75.1(28).

75.14(7) Notwithstanding subrule 75.14(6), any pregnant woman or previously pregnant woman establishing eligibility under subrule 75.1(28) or 75.1(24) shall not be exempt from the provisions of 75.14(4) that require an adult applicant or member to assign any rights to medical support and payments for medical care.

75.14(8) Good cause for refusal to cooperate. Good cause shall exist when it is determined that cooperation in establishing paternity and securing support is against the best interests of the child.

a. The income maintenance unit shall determine that cooperation is against the child’s best interest when the applicant’s or member’s cooperation in establishing paternity or securing support is reasonably anticipated to result in:

(1) Physical or emotional harm to the child for whom support is to be sought; or
(2) Physical or emotional harm to the parent or specified relative with whom the child is living which reduces the person’s capacity to care for the child adequately.

(3) Physical harm to the parent or specified relative with whom the child is living which reduces the person’s capacity to care for the child adequately; or
(4) Emotional harm to the parent or specified relative with whom the child is living of a nature or degree that it reduces the person’s capacity to care for the child adequately.

b. The income maintenance unit shall determine that cooperation is against the child’s best interest when at least one of the following circumstances exists, and the income maintenance unit believes that because of the existence of that circumstance, in the particular case, proceeding to establish paternity or secure support would be detrimental to the child for whom support would be sought.

(1) The child was conceived as the result of incest or forcible rape.
(2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction.

(3) The applicant or member is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

c. Physical harm and emotional harm shall be of a serious nature in order to justify a finding of good cause. A finding of good cause for emotional harm shall be based only upon a demonstration of an emotional impairment that substantially affects the individual’s functioning.

d. When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the child, the parent, or the specified relative, the following shall be considered:

(1) The present emotional state of the individual subject to emotional harm.
(2) The emotional health history of the individual subject to emotional harm.
(3) Intensity and probable duration of the emotional impairment.
(4) The degree of cooperation required.
(5) The extent of involvement of the child in the paternity establishment or support enforcement activity to be undertaken.

75.14(9) Claiming good cause. Each Medicaid applicant or member who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing support payments.

a. Before requiring cooperation, the department shall notify the applicant or member using Form 470-0169 or 470-0169(S), Requirements of Support Enforcement, of the right to claim good cause as
an exception to the cooperation requirement and of all the requirements applicable to a good cause
determination.

b. The initial notice advising of the right to refuse to cooperate for good cause shall:

(1) Advise the applicant or member of the potential benefits the child may derive from the
establishment of paternity and securing support.

(2) Advise the applicant or member that by law cooperation in establishing paternity and securing
support is a condition of eligibility for the Medicaid program.

(3) Advise the applicant or member of the sanctions provided for refusal to cooperate without good
cause.

(4) Advise the applicant or member that good cause for refusal to cooperate may be claimed and
that if the income maintenance unit determines, in accordance with these rules, that there is good cause,
the applicant or member will be excused from the cooperation requirement.

(5) Advise the applicant or member that upon request, or following a claim of good cause, the
income maintenance unit will provide further notice with additional details concerning good cause.

c. When the applicant or member makes a claim of good cause or requests additional information
regarding the right to file a claim of good cause, the income maintenance unit shall issue a second notice,
Form 470-0170, Requirements of Claiming Good Cause. To claim good cause, the applicant or member
shall sign and date Form 470-0170 and return it to the income maintenance unit. This form:

(1) Indicates that the applicant or member must provide corroborative evidence of good cause
circumstance and must, when requested, furnish sufficient information to permit the county office to
investigate the circumstances.

(2) Informs the applicant or member that, upon request, the income maintenance unit will provide
reasonable assistance in obtaining the corroborative evidence.

(3) Informs the applicant or member that on the basis of the corroborative evidence supplied
and the agency’s investigation when necessary, the income maintenance unit shall determine whether
cooperation would be against the best interests of the child for whom support would be sought.

(4) Lists the circumstances under which cooperation may be determined to be against the best
interests of the child.

(5) Informs the applicant or member that the child support recovery unit may review the income
maintenance unit’s findings and basis for a good cause determination and may participate in any hearings
concerning the issue of good cause.

(6) Informs the applicant or member that the child support recovery unit may attempt to establish
paternity and collect support in those cases where the income maintenance unit determines that this can
be done without risk to the applicant or member if done without the applicant’s or member’s participation.

d. The applicant or member who refuses to cooperate and who claims to have good cause for
refusing to cooperate has the burden of establishing the existence of a good cause circumstance. Failure
to meet these requirements shall constitute a sufficient basis for the income maintenance unit to determine
that good cause does not exist. The applicant or member shall:

(1) Specify the circumstances that the applicant or member believes provide sufficient good cause
for not cooperating.

(2) Corroborate the good cause circumstances.

(3) When requested, provide sufficient information to permit an investigation.

75.14(10) Determination of good cause. The income maintenance unit shall determine whether good
cause exists for each Medicaid applicant or member who claims to have good cause.

a. The income maintenance unit shall notify the applicant or member of its determination that
good cause does or does not exist. The determination shall:

(1) Be in writing.

(2) Contain the income maintenance unit’s findings and basis for determination.

(3) Be entered in the case record.

b. The determination of whether or not good cause exists shall be made within 45 days from the
day the good cause claim is made. The income maintenance unit may exceed this time standard only
when:
(1) The case record documents that the income maintenance unit needs additional time because the information required to verify the claim cannot be obtained within the time standard, or
(2) The case record documents that the claimant did not provide corroborative evidence within the time period set forth in subrule 75.14(11).
   c. When the income maintenance unit determines that good cause does not exist:
      (1) The applicant or member shall be so notified and be afforded an opportunity to cooperate, withdraw the application for assistance, or have the case closed; and
      (2) Continued refusal to cooperate will result in the loss of Medicaid for the person who refuses to cooperate.
   d. The income maintenance unit shall make a good cause determination based on the corroborative evidence supplied by the applicant or member only after the income maintenance unit has examined the evidence and found that it actually verifies the good cause claim.
   e. Before making a final determination of good cause for refusing to cooperate, the income maintenance unit shall:
      (1) Afford the child support recovery unit the opportunity to review and comment on the findings and basis for the proposed determination, and
      (2) Consider any recommendation from the child support recovery unit.
   f. The child support recovery unit may participate in any appeal hearing that results from an applicant’s or member’s appeal of an agency action with respect to a decision on a claim of good cause.
   g. Assistance shall not be denied, delayed, or discontinued pending a determination of good cause for refusal to cooperate when the applicant or member has specified the circumstances under which good cause can be claimed and provided the corroborative evidence and any additional information needed to establish good cause.
   h. The income maintenance unit shall:
      (1) Periodically, but not less frequently than every six months, review those cases in which the agency has determined that good cause exists based on a circumstance that is subject to change.
      (2) When it determines that circumstances have changed so that good cause no longer exists, rescind its findings and proceed to enforce the requirements pertaining to cooperation in establishing paternity and securing support.

75.14(11) Proof of good cause. The applicant or member who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the income maintenance unit determines that the applicant or member requires additional time because of the difficulty in obtaining the corroborative evidence, the income maintenance unit shall allow a reasonable additional period upon approval by the worker’s immediate supervisor.
   a. A good cause claim may be corroborated with the following types of evidence:
      (1) Birth certificates or medical or law enforcement records which indicate that the child was conceived as the result of incest or forcible rape.
      (2) Court documents or other records which indicate that legal proceedings for adoption are pending before a court of competent jurisdiction.
      (3) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the putative father or absent parent might inflict physical or emotional harm on the child or specified relative.
      (4) Medical records which indicate emotional health history and present emotional health status of the specified relative or the children for whom support would be sought; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the specified relative or the child for whom support would be sought.
      (5) A written statement from a public or licensed private social agency that the applicant or member is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.
      (6) Sworn statements from individuals other than the applicant or member with knowledge of the circumstances which provide the basis for the good cause claim.
b. When, after examining the corroborative evidence submitted by the applicant or member, the income maintenance unit wishes to request additional corroborative evidence which is needed to permit a good cause determination, the income maintenance unit shall:
   (1) Promptly notify the applicant or member that additional corroborative evidence is needed, and
   (2) Specify the type of document which is needed.

c. When the applicant or member requests assistance in securing evidence, the income maintenance unit shall:
   (1) Advise the applicant or member how to obtain the necessary documents, and
   (2) Make a reasonable effort to obtain any specific documents which the applicant or member is not reasonably able to obtain without assistance.

d. When a claim is based on the applicant’s or member’s anticipation of physical harm and corroborative evidence is not submitted in support of the claim:
   (1) The income maintenance unit shall investigate the good cause claim when the office believes that the claim is credible without corroborative evidence and corroborative evidence is not available.
   (2) Good cause shall be found when the claimant’s statement and investigation which is conducted satisfies the county office that the applicant or member has good cause for refusing to cooperate.
   (3) A determination that good cause exists shall be reviewed and approved or disapproved by the worker’s immediate supervisor and the findings shall be recorded in the case record.

e. The income maintenance unit may further verify the good cause claim when the applicant’s or member’s statement of the claim together with the corroborative evidence do not provide sufficient basis for making a determination. When the income maintenance unit determines that it is necessary, the unit may conduct an investigation of good cause claims to determine that good cause does or does not exist.

f. When it conducts an investigation of a good cause claim, the income maintenance unit shall:
   (1) Contact the absent parent or putative father from whom support would be sought when the contact is determined to be necessary to establish the good cause claim.
   (2) Before making the necessary contact, notify the applicant or member so the applicant or member may present additional corroborative evidence or information so that contact with the parent or putative father becomes unnecessary, withdraw the application for assistance or have the case closed, or have the good cause claim denied.

75.14(12) Enforcement without specified relative’s cooperation. When the income maintenance unit makes a determination that good cause exists, the unit shall also make a determination of whether or not child support enforcement can proceed without risk of harm to the child or specified relative when the enforcement or collection activities do not involve their participation.

a. The child support recovery unit shall have an opportunity to review and comment on the findings and basis for the proposed determination and the income maintenance unit shall consider any recommendations from the child support recovery unit.

b. The determination shall be in writing, contain the income maintenance unit’s findings and basis for the determination, and be entered into the case record.

c. When the income maintenance unit excuses cooperation but determines that the child support recovery unit may proceed to establish paternity or enforce support, the income maintenance unit shall notify the applicant or member to enable the individual to withdraw the application for assistance or have the case closed.

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

[ARC 8785B, IAB 6/2/10, effective 8/1/10]

441—75.15(249A) Disqualification for long-term care assistance due to substantial home equity. Notwithstanding any other provision of this chapter, if an individual’s equity interest in the individual’s home exceeds $500,000, the individual shall not be eligible for medical assistance with respect to nursing facility services or other long-term care services except as provided in 75.15(2). This provision is effective for all applications or requests for payment of long-term care services filed on or after January 1, 2006.
75.15(1) The limit on the equity interest in the individual’s home for purposes of this rule shall be increased from year to year, beginning with 2011, based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

75.15(2) Disqualification based on equity interest in the individual’s home shall not apply when one of the following persons is lawfully residing in the home:
   a. The individual’s spouse; or
   b. The individual’s child who is under age 21 or is blind or disabled as defined in Section 1614 of the federal Social Security Act.

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

441—75.16(249A) Client participation in payment for medical institution care. Medicaid clients are required to participate in the cost of medical institution care. However, no client participation is charged when the combination of Medicare payments and the Medicaid benefits available to qualified Medicare beneficiaries covers the cost of institutional care.

75.16(1) Income considered in determining client participation. The department determines the amount of client participation based on the client’s total monthly income, with the following exceptions:
   a. FMAP-related clients. The income of a client and family whose eligibility is FMAP-related is not available for client participation when both of the following conditions exist:
      (1) The client has a parent or child at home.
      (2) The family’s income is considered together in determining eligibility.
   b. SSI-related clients who are employed. If a client receives SSI and is substantially gainfully employed, as determined by the Social Security Administration, the client shall have the SSI and any mandatory state supplementary assistance payment exempt from client participation for the two full months after entry to a medical institution.
   c. SSI-related clients returning home within three months. If the Social Security Administration continues a client’s SSI or federally administered state supplementary assistance payments for three months because it is expected that the client will return home within three months, these payments shall be exempt from client participation.
   d. Married couples.
      (1) Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized person’s income shall be considered in determining client participation.
      (2) Both spouses institutionalized. Client participation for each partner in a marriage shall be based on one-half of the couple’s combined income when the partners are considered together for eligibility. Client participation for each partner who is considered individually for eligibility shall be determined individually from each person’s income.
      (3) Rescinded, IAB 7/11/90, effective 7/1/90.
   e. State supplementary assistance recipients. The amount of client participation that a client paid under the state supplementary assistance program is not available for Medicaid client participation in the month of the client’s entry to a medical institution.
   f. Foster care recipients. The amount of income paid for foster care for the days that a child is in foster care in the same month as entry to a medical institution is not available for client participation.
   g. Clients receiving a VA pension. The amount of $90 of veteran’s pension income shall be exempt from client participation if the client is a veteran or a surviving spouse of a veteran who:
      (1) Receives a reduced pension pursuant to 38 U.S.C. Section 5503(d)(2), or
      (2) Resides at the Iowa Veterans Home and does not have a spouse or minor child.

75.16(2) Allowable deductions from income. In determining the amount of client participation, the department allows the following deductions from the client’s income, taken in the order they appear:
   a. Ongoing personal needs allowance. All clients shall retain $50 of their monthly income for a personal needs allowance. (See rules 441—81.23(249A), 441—82.19(249A), and 441—85.47(249A) regarding potential state-funded personal needs supplements.)
      (1) If the client has a trust described in Section 1917(d)(4) of the Social Security Act (including medical assistance income trusts and special needs trusts), a reasonable amount paid or set aside for
necessary expenses of the trust is added to the personal needs allowance. This amount shall not exceed $10 per month except with court approval.

(2) If the client has earned income, an additional $65 is added to the ongoing personal needs allowance from the earned income only.

(3) Recesed IAB 7/4/07, effective 7/1/07.
   b. Personal needs in the month of entry.
   (1) Single person. A single person shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a single person.
   (2) Spouses entering institutions together and living together. Partners in a marriage who enter a medical institution in the same month and live in the same room shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a couple.
   (3) Spouses entering an institution together but living apart. Partners in a marriage who enter a medical institution during the same month and who are considered separately for eligibility shall each be given an allowance for stated home living expenses during the month of entry, up to one-half of the amount of the SSI benefit for a married couple. However, if the income of one spouse is less than one-half of the SSI benefit for a couple, the remainder of the allowance shall be given to the other spouse. If the couple’s eligibility is determined together, an allowance for stated home living expenses shall be given to them during the month of entry up to the SSI benefit for a married couple.
   (4) Community spouse enters a medical institution. When the second member of a married couple enters a medical institution in a later month, that spouse shall be given an allowance for stated expenses during the month of entry, up to the amount of the SSI benefit for one person.
   c. Personal needs in the month of discharge. The client shall be allowed a deduction for home living expenses in the month of discharge. The amount of the deduction shall be the SSI benefit for one person (or for a couple, if both members are discharged in the same month). This deduction does not apply when a spouse is at home.
   d. Maintenance needs of spouse and other dependents.
   (1) Persons covered. An ongoing allowance shall be given for the maintenance needs of a community spouse. The allowance is limited to the extent that income of the institutionalized spouse is made available to or for the benefit of the community spouse. If there are minor or dependent children, dependent parents, or dependent siblings of either spouse who live with the community spouse, an ongoing allowance shall also be given to meet their needs.
   (2) Income considered. The verified gross income of the spouse and dependents shall be considered in determining maintenance needs. The gross income of the spouse and dependent shall include all monthly earned and unearned income and assistance from the family investment program (FIP), supplemental security income (SSI), and state supplementary assistance (SSA). It shall also include the proceeds of any annuity or contract for sale of real property. Otherwise, the income shall be considered as the SSI program considers income. In addition, the spouse and dependents shall be required to apply for every income benefit for which they are eligible except that they shall not be required to accept SSI, FIP or SSA in lieu of the maintenance needs allowance. Failure to apply for all benefits shall mean reduction of the maintenance needs allowance by the amount of the anticipated income from the source not applied for.
   (3) Needs of spouse. The maintenance needs of the spouse shall be determined by subtracting the spouse’s gross income from the maximum amount allowed as a minimum monthly maintenance needs allowance for the community spouse by Section 1924(d)(3)(C) of the Social Security Act (42 U.S.C. § 1396r-5(d)(3)(C)). (This amount is indexed for inflation annually according to the consumer price index.)

   However, if either spouse has established through the appeal process that the community spouse needs income above the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, an amount adequate to provide additional income as is necessary shall be substituted.

   Also, if a court has entered an order against an institutionalized spouse for monthly income to support the community spouse, then the community spouse income allowance shall not be less than this amount.
(4) Needs of other dependents. The maintenance needs of the other dependents shall be established by subtracting each person’s gross income from 133 percent of the monthly federal poverty level for a family of two and dividing the result by three. (Effective July 1, 1992, the percent shall be 150 percent.)

e. Maintenance needs of children (without spouse). When the client has children under 21 at home, an ongoing allowance shall be given to meet the children’s maintenance needs.

The income of the children is considered in determining maintenance needs. The children’s countable income shall be their gross income less the disregards allowed in the FIP program.

The children’s maintenance needs shall be determined by subtracting the children’s countable income from the FIP payment standard for that number of children. (However, if the children receive FIP, no deduction is allowed for their maintenance needs.)

f. Client’s medical expenses. A deduction shall be allowed for the client’s incurred expenses for medical or remedial care that are not subject to payment by a third party and were not incurred for long-term care services during the imposition of a transfer of assets penalty period pursuant to rule 441—75.23(249A). This includes Medicare premiums and other health insurance premiums, deductibles or coinsurance, and necessary medical or remedial care recognized under state law but not covered under the state Medicaid plan.

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

[ARC 8444B, IAB 1/13/10, effective 3/1/10]

441—75.17(249A) Verification of pregnancy. For the purpose of establishing Medicaid eligibility for pregnant women under this chapter, the applicant’s self-declaration of the pregnancy and the date of conception shall serve as verification of pregnancy, unless questionable.

47.17(1) Multiple pregnancy. If the pregnant woman claims to be carrying more than one fetus, a medical professional who has examined the woman must verify the number of fetuses in order for more than one to be considered in the household size.

75.17(2) Cost of examination. When an examination is required and other medical resources are not available to meet the expense of the examination, the provider shall be authorized to make the examination and submit the claim for payment.

This rule is intended to implement Iowa Code section 249A.3.

441—75.18(249A) Continuous eligibility for pregnant women. A pregnant woman who applies for Medicaid prior to the end of her pregnancy and subsequently establishes initial Medicaid eligibility under the provisions of this chapter shall remain continuously eligible throughout the pregnancy and the 60-day postpartum period, as provided in subrule 75.1(24), regardless of any changes in family income.

This rule is intended to implement Iowa Code section 249A.3.

441—75.19(249A) Continuous eligibility for children. A child under the age of 19 who is determined eligible for ongoing Medicaid shall retain that eligibility for up to 12 months regardless of changes in family circumstances except as described in this rule.

75.19(1) Exceptions to coverage. This rule does not apply to the following children:

a. Children whose eligibility was determined under the newborn coverage group described at subrule 75.1(20).

b. Children whose eligibility was determined under the medically needy coverage group described at subrule 75.1(35).

c. Children whose medical assistance is state-funded only.

d. Children whose citizenship is not verified within the “reasonable period” described at paragraph 75.11(2)”c.”

e. Children who are eligible only in a retroactive month.

75.19(2) Duration of coverage. Coverage under this rule shall extend through the earliest of the following months:

a. The month of the household’s annual eligibility review;

b. The month when the child reaches the age of 19; or
c. The month when the child moves out of Iowa.

75.19(3) Assignment of review date. Children entering an existing Medicaid household shall be assigned the same annual eligibility review date as that established for the household.

This rule is intended to implement Iowa Code Supplement section 249A.3 as amended by 2008 Iowa Acts, House File 2539.

[ARC 8786B, IAB 6/2/10, effective 6/1/10; ARC 3353C, IAB 10/11/17, effective 10/1/17; ARC 3549C, IAB 1/3/18, effective 2/7/18]

441—75.20(249A) Disability requirements for SSI-related Medicaid.

75.20(1) Applicants receiving federal benefits. An applicant receiving supplemental security income on the basis of disability, social security disability benefits under Title II of the Social Security Act, or railroad retirement benefits based on the Social Security law definition of disability by the Railroad Retirement Board, shall be deemed disabled without further determination of disability.

75.20(2) Applicants not receiving federal benefits. When disability has not been established based on the receipt of social security disability or railroad retirement benefits based on the same disability criteria as used by the Social Security Administration, the department shall determine eligibility for SSI-related Medicaid based on disability as follows:

a. A Social Security Administration (SSA) disability determination under either a social security disability (Title II) application or a supplemental security income application is binding on the department until changed by SSA unless the applicant meets one of the following criteria:

   (1) The applicant alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination.
   (2) The applicant alleges more than 12 months after the most recent SSA determination denying disability that the applicant’s condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements, and has not applied to SSA for a determination with respect to these allegations.
   (3) The applicant alleges less than 12 months after the most recent SSA determination denying disability that the applicant’s condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements, and:
      1. The applicant has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations, or
      2. The applicant no longer meets the nondisability requirements for SSI but may meet the department’s nondisability requirements for Medicaid eligibility.

b. When there is no binding SSA decision and the department is required to establish eligibility for SSI-related Medicaid based on disability, initial determinations shall be made by disability determination services, a bureau of the Iowa department of education under the division of vocational rehabilitation services. The applicant or the applicant’s authorized representative shall complete and submit Form 470-4459 or 470-4459(S), Authorization to Disclose Information to the Department of Human Services, and either:

   (1) Form 470-2465, Disability Report for Adults, if the applicant is aged 18 or over; or
   (2) Form 470-3912, Disability Report for Children, if the applicant is under the age of 18.
   c. When an SSA decision on disability is pending when the person applies for Medicaid or when the person applies for either Title II benefits or SSI within ten working days of the Medicaid application, the department shall stay a decision on disability pending the SSA decision on disability.

75.20(3) Time frames for decisions. Determination of eligibility based on disability shall be completed within 90 days unless the applicant or an examining physician delays or fails to take a required action, or there is an administrative or other emergency beyond the department’s or applicant’s control.

75.20(4) Reviews of disability. In connection with any independent determination of disability, the department will determine whether reexamination of the member’s disability will be required for periodic eligibility reviews. When a disability review is required, the member or the member’s authorized representative shall complete and submit the same forms as required in paragraph 75.20(2) “b.”
75.20(5) Members whose disability was determined by the department. When a Medicaid member has been approved for Medicaid based on disability determined by the department and later is determined by SSA not to be disabled for SSI, the member shall continue to be considered disabled for Medicaid eligibility purposes for 65 days from the date of the SSA denial. If at the end of the 65 days there is no appeal to the SSA, Medicaid shall be canceled with timely notice. If there is an appeal within 65 days, the member shall continue to be considered disabled for Medicaid eligibility purposes until a final SSA decision.

75.20(6) Disability redeterminations for members who attain age 18. If a member is eligible based on an independent determination of disability made under the standards applicable to persons under 18 years of age, the department shall redetermine the member’s disability after the member attains the age of 18 years. The member’s disability shall be redetermined:

   a. Using the standards applicable to persons who are 18 years of age or older, and
   b. Regardless of whether a review of the member’s disability would otherwise be due.

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

[ARC 9044B, IAB 9/8/10, effective 11/1/10]

441—75.21(249A) Health insurance premium payment (HIPP) program. Under the HIPP program, the department shall pay for the cost of premiums, coinsurance, copayments, and deductibles for Medicaid-eligible individuals when the department determines that those costs will be less than the cost of paying for the individual’s care through Medicaid including managed care capitation fees. Payment shall include only the cost to the Medicaid-eligible individual or household.

75.21(1) Definitions.

   “Absent parent” means a noncustodial parent, or a parent who is not living with the member.
   “Authorized representative” means an individual or organization authorized by a competent applicant or member, authorized by a responsible person acting for an incompetent applicant or member pursuant to 441—subrule 76.9(2), or with other legal authority to represent the applicant or member in the application process, renewal of eligibility and other ongoing communications with the department.
   “Capitation payment” means a monthly payment to the managed care contractor on behalf of each member for the provision of health services under the managed care entity contract. Payment is made by the department regardless of whether the member receives services during the month. The managed care capitation payment varies based on the eligible member’s sex, age, and eligibility aid type.
   “Cost-effective” means a determination has been made that a savings will accrue to the department by paying the insurance premium, cost sharing, wrap benefits, and administrative cost.
   “Cost sharing” means the member’s portions of in-network health care costs not covered by an insurance plan. “Cost sharing” includes copayments, coinsurance and deductibles, which vary among health care plans.
   “Custodian” means the person recognized as representing the interests of the member for Medicaid assistance. When the member reaches the age of 18 and the custodian is not used in determining Medicaid eligibility, there shall be legal documentation in place that the custodian is now the responsible person or authorized representative.
   “Department” means the Iowa department of human services.
   “Employer-sponsored insurance” or “ESI” means any health insurance plan paid for by a business on behalf of its employees.
   “High-deductible health plan” or “HDHP” means a health insurance plan that meets the definition found in Section 223(c)(2) of the Internal Revenue Code.
   “HIPP-eligible member” means a person whose Medicaid eligibility is calculated in the cost-effective determination for HIPP. “HIPP-eligible member” is also referred to as HIPP enrollee.
   “Household” means the group of people who are used in the budgeting and size when determining Medicaid eligibility.
   “Individual plan” means an insurance plan purchased through a government-run health insurance marketplace or through a local broker or agent.
“Insurance plan” means major medical comprehensive health coverage provided through an employer, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), a government-run health insurance marketplace, or a local broker or agent. Dental and vision plans are not considered to be insurance plans for purposes of this definition.

“Member” means an individual who has been determined eligible for Medicaid assistance and is enrolled to receive assistance.

“Policyholder” means the person in whose name an insurance policy is registered.

“Responsible person” means an individual recognized by the department pursuant to 441—subrule 76.9(1) as acting for an applicant or member who is unable to act on the applicant’s or member’s own behalf because the applicant or member is a minor or is incompetent, incapacitated, or deceased.

“Wrap benefits” means the services covered under the Medicaid state plans that are not paid for by insurance plans (i.e., waiver services, transportation).

75.21(2) Insurance plans. Participation in an insurance plan is not a condition of Medicaid eligibility. The department shall pay for the cost of the insurance plan premiums, coinsurance, copayment, and deductibles of an insurance plan for a member if:

- A member is enrolled in or can be added to the insurance plan; and
- The insurance plan is cost-effective as defined in subrule 75.21(3).

75.21(3) Cost-effectiveness. An insurance plan shall be considered cost-effective when the amount the department would pay for the member’s insurance premiums, cost sharing, wrap benefits, and administrative costs is likely to be less than the amount the department would pay through Medicaid including managed care capitation fees. When determining the cost-effectiveness of an insurance plan, the following data shall be considered:

- The cost to the member or household for the insurance premium, coinsurance, copayments and deductibles. No costs paid by an employer or other plan sponsor shall be considered in the cost-effectiveness determination.
- The cost of care through Medicaid including managed care capitation fees the department would pay for the member.
- The estimated cost of wrap benefits per member based on the member’s sex, age, and eligibility aid type.
- The specific health-related circumstances of the members covered under the health plan. Form 470-2868, HIPP Medical History Questionnaire, shall be used to obtain this information. When the information indicates any health conditions that could be expected to result prospectively in higher-than-average bills for any Medicaid member:
  1. If the member is currently covered by the insurance plan, the department shall request from the policyholder, or the responsible person for the member, an insurance summary of the member’s paid claims for the previous 12 months. If there is sufficient evidence to indicate that such claims can be expected to continue in the next 12 months, the claims will be considered in determining the cost-effectiveness of the insurance plan. The cost of the insurance plan premium, member’s cost sharing, and administrative cost are compared to the actual claims to determine the cost-effectiveness of providing the coverage.
  2. If the member was not covered by the health plan in the previous 12 months, fee-for-service paid Medicaid claims may be used to project the cost-effectiveness of the plan.
- Annual administrative expenditures of $150 per HIPP member covered under the health plan.
- Whether the estimated savings to the department for members covered under the health insurance plan is at least $5 per month per household.

75.21(4) Coverage of non-Medicaid-eligible family members. When an insurance plan is determined to be cost-effective, the department shall pay for insurance premiums for non-Medicaid-eligible family members if a non-Medicaid-eligible family member must be enrolled in the insurance plan in order to obtain coverage for the Medicaid-eligible family members. However:

- The needs of the non-Medicaid-eligible family members shall not be taken into consideration when determining cost-effectiveness; and
b. Payments for deductibles, coinsurances or other cost-sharing obligations shall not be made on behalf of family members who are not Medicaid-eligible.

75.21(5) Insurance plans ineligible for reimbursement. Premiums shall not be paid for insurance plans under any of the following circumstances:
   a. The insurance plan is that of an absent parent.
   b. The insurance plan is an indemnity policy which supplements the policyholder’s income or pays only a predetermined amount for services covered under the policy (e.g., $50 per day for hospital services instead of 80 percent of the charge).
   c. The insurance plan is a school plan offered on the basis of attendance or enrollment at the school.
   d. The insurance premium is used to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), when all persons in the household are eligible or potentially eligible only under the medically needy program. When some of the household members are eligible for full Medicaid benefits under coverage groups other than medically needy, the premium shall be paid if it is determined to be cost-effective when considering only the persons receiving full Medicaid coverage. In those cases, the insurance premium shall not be allowed as a deduction to meet the spenddown obligation for those persons in the household participating in the medically needy program.
   e. The insurance plan is designed to provide coverage only for a temporary period of time (e.g., 30 to 180 days).
   f. The persons covered under the insurance plan are not Medicaid-eligible on the date the decision regarding eligibility for the HIPP program is made. No retroactive payments shall be made if the case is not Medicaid-eligible on the date of decision.
   g. The person is eligible only for a coverage group that does not provide full Medicaid services.
   h. Insurance coverage is provided through the health insurance plan of Iowa (HIPIOWA), in accordance with Iowa Code chapter 514E.
   i. Insurance on the member(s) is maintained by someone who does not live with the member(s), is not the legal guardian of the member(s), is not a responsible person, or does not have legal permission to access the Medicaid information of the member(s) (e.g., self-supporting adult children).
   j. The member has Medicare. If other members in the household are covered by the insurance plan, cost-effectiveness is determined without including the Medicare-covered member.
   k. The insurance plan does not provide major medical coverage but pays only for specific situations (i.e., accident plans) or illnesses (i.e., cancer policy).
   l. The health plan pays secondary to another plan.
   m. The only Medicaid member is in foster care.
   n. The member is active for Medicaid under Medicaid for children with disabilities (i.e., Medicaid for kids with special needs (MKSN)), pursuant to subrule 75.1(43). Any other Medicaid members in the household who are covered by the health plan shall be determined for cost-effectiveness.
   o. The insurance plan is limited due to preexisting conditions.
   p. The insurance plan is a subsidized insurance plan purchased through a government-run health insurance exchange.
   q. On the date the decision regarding eligibility for the HIPP program is made, the insurance is no longer available.
   r. The insurance plan is an HDHP.

75.21(6) Department evaluation of ESI plans. When evaluating ESI plans available through an employer, if there is more than one cost-effective insurance plan available, the department shall pay the premium for only one plan. The member may choose the cost-effective plan in which to enroll.

75.21(7) Effective date of premium payment. The effective date of premium payments for a cost-effective health plan shall be determined as follows:
   a. Premium payments shall begin the later of:
      (1) The first day of the month in which Form 470-2844, Employer’s Statement of Earnings; Form 470-2875, Health Insurance Premium Payment (HIPP) Program Application; or Form H301-1, the automated HIPP referral; is received by the HIPP unit; or
(2) The first day of the first month in which the health plan is determined to be cost-effective.

b. If the person is not enrolled in the insurance plan when eligibility for participation in the HIPP program is established, premium payments shall begin in the month in which the first premium payment is due after enrollment occurs.

c. If there was a lapse in coverage during the application process (e.g., the health plan is dropped and reenrollment occurs at a later date), premium payments shall not be made for any period of time before the current effective date of coverage.

d. In no case shall payments be made for premiums that were used as a deduction to income for determining client participation or the amount of the spenddown obligation.

e. Form 470-3036, Employer Verification of Insurance Coverage, shall be used to verify the effective date of coverage and costs for persons enrolled in group health plans through an employer.

f. The effective date of coverage of an insurance plan not obtained through an employer shall be verified by a copy of the certificate of coverage for the plan or by some other verification from the insurer.

75.21(8) Method of premium payment. Payments of premiums will be made directly to the insurance carrier except as follows:

a. The department may arrange for payment to an employer in order to circumvent a payroll deduction.

b. When an employer will not agree to accept premium payments from the department in lieu of a payroll deduction to the employee’s wages, the department shall reimburse the employee directly for payroll deductions or for payments made directly to the employer for the payment of premiums. The department shall issue reimbursement to the employee five working days before the employee’s pay date.

c. When premium payments are occurring through an automatic withdrawal from a bank account by the insurance carrier, the department may reimburse the policyholder for those withdrawals.

d. Payments for COBRA coverage shall be made directly to the insurance carrier, the COBRA administrator, or the former employer. Payments may be made directly to the former employee only in those cases where:

(1) Information cannot be obtained for direct payment; or

(2) The department pays for only part of the total premium.

75.21(9) Payment of claims. Claims from medical providers for persons participating in this program shall be paid in the same manner as claims are paid for other persons with a third-party resource in accordance with the provisions of 441—Chapters 79 and 80.

75.21(10) Reviews of cost-effectiveness and eligibility. Reviews of cost-effectiveness and eligibility shall be completed annually and may be conducted more frequently at the discretion of the department.

a. Annual review of ESI cost-effectiveness and eligibility shall be completed using Form 470-3016, Health Insurance Premium Payment (HIPP) Program Review.

b. Annual review of individual health plan cost-effectiveness and eligibility shall be completed using Form 470-3017, HIPP Private Policy Review.

c. Failure of the household to cooperate in the annual review process shall result in cancellation of premium payment.

d. Redeterminations shall be completed whenever:

(1) A premium rate, copayment, deductible, or coinsurance changes;

(2) A person covered under the policy loses full Medicaid eligibility;

(3) Changes in employment or hours of employment affect the availability of an insurance plan;

(4) The insurance carrier changes;

(5) The policyholder leaves the Medicaid home;

(6) There is a decrease in the services covered under the policy; or

(7) The Medicaid category of coverage changes.

e. The policyholder shall report changes that may affect the availability of the insurance plan reimbursed by the HIPP program, or changes that affect the cost-effectiveness of the policy, within ten calendar days from the date of the change.
f. If a change in the number of members in the Medicaid household causes the health plan not to be cost-effective, lesser health plan options, as defined in paragraph 75.21(15) "a," shall be considered if available and cost-effective.

g. When employment ends, hours of employment are reduced, or some other qualifying event affecting the availability of the group health plan occurs, the department shall verify whether coverage may be continued under the provisions of COBRA.

(1) Form 470-3037, Employer Verification of COBRA Eligibility, may be used for this purpose.

(2) If cost-effective to do so, the department shall pay premiums to maintain insurance coverage for members after the occurrence of the event which would otherwise result in termination of coverage.

75.21(11) Time frames for determining cost-effectiveness. The department shall determine cost-effectiveness of the insurance plan and notify the applicant of the decision regarding payment of the premiums within 65 calendar days from the date an application or referral (as defined in subrule 75.21(7)) is received. Additional time may be taken when, for reasons beyond the control of the department or the applicant, information needed to establish cost-effectiveness cannot be obtained within the 65-day period.

75.21(12) Notices.

a. Adequate notice shall be provided to the household under the following circumstances:

(1) To inform the household of the initial decision on cost-effectiveness and premium payment.

(2) To inform the household that premium payments are being discontinued because Medicaid eligibility has been lost by all persons covered under the health plan.

(3) The insurance plan is no longer available to the family (e.g., the employer no longer provides health insurance coverage or the policy is terminated by the insurance company).

b. The department shall provide timely and adequate notice as defined in 441—subrule 7.7(1) to inform the household of a decision to discontinue payment of the health insurance premium because:

(1) The department has determined the insurance plan is no longer cost-effective; or

(2) The member has failed to cooperate in providing information necessary to establish continued eligibility for the HIPP program.

75.21(13) Rate refund. The department shall be entitled to any rate refund made when the insurance carrier determines a return of premiums to the policyholder is due for any time period for which the department paid the premium.

75.21(14) Reinstatement of HIPP eligibility.

a. When eligibility for the HIPP program is canceled because the persons covered under the insurance plan lose Medicaid eligibility, HIPP eligibility shall be reinstated when Medicaid eligibility is reestablished if all other eligibility factors are met.

b. When HIPP eligibility is canceled because of the policyholder’s failure to cooperate in providing information necessary to establish continued eligibility for the HIPP program, benefits shall be reinstated the first day of the first month in which cooperation occurs, if all other eligibility factors are met.

75.21(15) Amount of insurance premium paid.

a. For ESI plans, the policyholder shall provide verification of the cost of all possible insurance plan options (i.e., single, employee/children, family).

(1) The HIPP program shall pay only for the option that provides coverage to the cost-effective members of the household.

(2) The HIPP program shall not pay the portion of the premium cost which is the responsibility of the employer or other plan sponsor.

b. For individual health plans, the HIPP program shall pay the cost of covering the cost-effective members covered by the plan.

c. For insurance plans, if another household member must be covered to obtain coverage for the members, the HIPP program shall pay the cost of covering that household member if the coverage is cost-effective as determined pursuant to subrules 75.21(3) and 75.21(4).

75.21(16) Reporting changes. Failure to report and verify changes may result in cancellation of HIPP benefits.
a. The policyholder shall verify changes by providing a pay stub, a summary of benefits and coverage, a rate sheet, or a letter from the insurance carrier reflecting the change.

b. Changes in employment or the employment-related insurance carrier shall be verified by the employer.

c. Any benefits paid during a period in which there was ineligibility for HIPP due to unreported changes shall be subject to recovery in accordance with the provisions of 441—Chapter 11.

d. Any underpayment that results from an unreported change shall be paid effective the first day of the month in which the change is reported.

75.21(17) Discontinuation of premium payments.

a. When the household loses Medicaid eligibility, premium payments shall be discontinued as of the month of Medicaid ineligibility.

b. When only part of the household loses Medicaid eligibility, the department shall complete a review in order to ascertain whether payment of the health insurance premium continues to be cost-effective. If the department determines that the insurance plan is no longer cost-effective, premium payment shall be discontinued pending timely and adequate notice.

c. If the household fails to cooperate in providing information necessary to establish ongoing eligibility for the HIPP program, the department shall discontinue premium payment after timely and adequate notice. The department shall request all information in writing and allow the household ten calendar days in which to provide it.

d. If the policyholder leaves the Medicaid household, premium payments shall be discontinued pending timely and adequate notice.

e. If the insurance plan is no longer available or the policy has lapsed, premium payments shall be discontinued as of the effective date of the termination of the coverage.

This rule is intended to implement Iowa Code section 249A.3.

[ARC 3493C, IAB 12/6/17, effective 1/10/18]

441—75.22(249A) AIDS/HIV health insurance premium payment program. For the purposes of this rule, “AIDS” and “HIV” are defined in accordance with Iowa Code section 141A.1.

75.22(1) Conditions of eligibility. The department shall pay for the cost of continuing health insurance coverage to persons with AIDS or HIV-related illnesses when the following criteria are met:

a. The person with AIDS or HIV-related illness shall be the policyholder, or the spouse of the policyholder, of an individual or group health plan.

b. The person shall be a resident of Iowa in accordance with the provisions of rule 441—75.10(249A).

c. The person shall not be eligible for Medicaid. The person shall be required to apply for Medicaid benefits when it appears Medicaid eligibility may exist. Persons who are required to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), are not considered Medicaid-eligible for the purpose of establishing eligibility under these provisions.

When Medicaid eligibility is attained, premium payments shall be made under the provisions of rule 441—75.21(249A) if all criteria of that rule are met.

d. A physician’s statement shall be provided verifying the policyholder or the spouse of the policyholder suffers from AIDS or an HIV-related illness. The physician’s statement shall also verify that the policyholder or the spouse of the policyholder is or will be unable to continue employment in the person’s current position or that hours of employment will be significantly reduced due to AIDS or HIV-related illness. The Physician’s Verification of Diagnosis, Form 470-2958, shall be used to obtain this information from the physician.

e. Gross income shall not exceed 300 percent of the federal poverty level for a family of the same size. The gross income of all family members shall be counted using the definition of gross income under the supplemental security income (SSI) program.

f. Liquid resources shall not exceed $10,000 per household. The following are examples of countable resources:

(1) Unobligated cash.
(2) Bank accounts.
(3) Stocks, bonds, certificates of deposit, excluding Internal Revenue Service defined retirement plans.

g. The health insurance plan must be cost-effective based on the amount of the premium and the services covered.

75.22(2) Application process.

a. Application. Persons applying for participation in this program shall complete the AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953. The applicant shall be required to provide documentation of income and assets. The application shall be available from and may be filed at any county departmental office or at the Division of Medical Services, Department of Human Services, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

An application shall be considered as filed on the date an AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953, containing the applicant’s name, address and signature is received and date-stamped in any county departmental office or the division of medical services.

b. Time limit for decision. Every reasonable effort will be made to render a decision within 30 days. Additional time for rendering a decision may be taken when, due to circumstances beyond the control of the applicant or the department, a decision regarding the applicant’s eligibility cannot be reached within 30 days (e.g., verification from a third party has not been received).

c. Eligible on the day of decision. No payments will be made for current or retroactive premiums if the person with AIDS or an HIV-related illness is deceased prior to a final eligibility determination being made on the application, if the insurance plan has lapsed, or if the person has otherwise lost coverage under the insurance plan.

d. Waiting list. After funds appropriated for this purpose are obligated, pending applications shall be denied by the division of medical services. A denial shall require a notice of decision to be mailed within ten calendar days following the determination that funds have been obligated. The notice shall state that the applicant meets eligibility requirements but no funds are available and that the applicant will be placed on the waiting list, or that the applicant does not meet eligibility requirements. Applicants not awarded funding who meet the eligibility requirements will be placed on a statewide waiting list according to the order in which the completed applications were filed. In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the day of the month of the applicant’s birthday, lowest number being first on the waiting list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

75.22(3) Presumed eligibility. The applicant may be presumed eligible to participate in the program for a period of two calendar months or until a decision regarding eligibility can be made, whichever is earlier. Presumed eligibility shall be granted when:

a. The application is accompanied by a completed Physician’s Verification of Diagnosis, Form 470-2958.

b. The application is accompanied by a premium statement from the insurance carrier indicating the policy will lapse before an eligibility determination can be made.

c. It can be reasonably anticipated that the applicant will be determined eligible from income and resource statements on the application.

75.22(4) Family coverage. When the person is enrolled in a policy that provides health insurance coverage to other members of the family, only that portion of the premium required to maintain coverage for the policyholder or the policyholder’s spouse with AIDS or an HIV-related illness shall be paid under this rule unless modification of the policy would result in a loss of coverage for the person with AIDS or an HIV-related illness.

75.22(5) Method of premium payment. Premiums shall be paid in accordance with the provisions of subrule 75.21(8).

75.22(6) Effective date of premium payment. Premium payments shall be effective with the month of application or the effective date of eligibility, whichever is later.

75.22(7) Reviews. The circumstances of persons participating in the program shall be reviewed quarterly to ensure eligibility criteria continues to be met. The AIDS/HIV Health Insurance Premium
Payment Program Review, Form 470-2877, shall be completed by the recipient or someone acting on the recipient’s behalf for this purpose.

75.22(8) Termination of assistance. Premium payments for otherwise eligible persons shall be paid under this rule until one of the following conditions is met:

a. The person becomes eligible for Medicaid. In which case, premium payments shall be paid in accordance with the provisions of rule 441—75.21(249A).

b. The insurance coverage is no longer available.

c. Maintaining the insurance plan is no longer considered the most cost-effective way to pay for medical services.

d. Funding appropriated for the program is exhausted.

e. The person with AIDS or an HIV-related illness dies.

f. The person fails to provide requested information necessary to establish continued eligibility for the program.

75.22(9) Notices.

a. An adequate notice as defined in 441—subrule 7.7(1) shall be provided under the following circumstances:

1. To inform the applicant of the initial decision regarding eligibility to participate in the program.

2. To inform the recipient that premium payments are being discontinued under these provisions because Medicaid eligibility has been attained and premium payments will be made under the provisions of rule 441—75.21(249A).

3. To inform the recipient that premium payments are being discontinued because the policy is no longer available.

4. To inform the recipient that premium payments are being discontinued because funding for the program is exhausted.

5. The person with AIDS or an HIV-related illness dies.

b. A timely and adequate notice as defined in 441—subrule 7.7(1) shall be provided to the recipient informing the recipient of a decision to discontinue payment of the health insurance premium when the recipient no longer meets the eligibility requirements of the program or fails to cooperate in providing information to establish eligibility.

75.22(10) Confidentiality. The department shall protect the confidentiality of persons participating in the program in accordance with Iowa Code section 141A.9. When it is necessary for the department to contact a third party to obtain information in order to determine initial or ongoing eligibility, a Consent to Obtain and Release Information, Form 470-0429, shall be signed by the recipient authorizing the department to make the contact.

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

441—75.23(249A) Disposal of assets for less than fair market value after August 10, 1993. In determining Medicaid eligibility for persons described in 441—Chapters 75 and 83, a transfer of assets occurring after August 10, 1993, will affect Medicaid payment for medical services as provided in this rule.

75.23(1) Ineligibility for services. When an individual or spouse has transferred or disposed of assets for less than fair market value as defined in 75.23(11) on or after the look-back date specified in 75.23(2), the individual shall be ineligible for medical assistance as provided in this subrule.

a. Institutionalized individual. When an institutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the institutionalized individual is ineligible for medical assistance payment for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, and home- and community-based waiver services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

1. Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).
(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or
2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving nursing facility services, a level of care in any institution equivalent to that of nursing facility services, or home- and community-based waiver services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

a. Noninstitutionalized individual. When a noninstitutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the individual is ineligible for medical assistance payment for home health care services, home and community care for functionally disabled elderly individuals, personal care services, and other long-term care services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

   (1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

   (2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

      1. The first day of the first month during which the assets were transferred; or
      2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving home health care services, home and community care for functionally disabled elderly individuals, personal care services, and other long-term care services, based on an approved application for such care, but for the application of this rule.

   (3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

b. Client participation after period of ineligibility. Expenses incurred for long-term care services during a transfer of assets penalty period may not be deducted as medical expenses in determining client participation pursuant to subrule 75.16(2).

75.23(2) Look-back date.

a. Transfer before February 8, 2006. For transfers made before February 8, 2006, the look-back date is the date that is 36 months (or, in the case of payments from a trust or portion of a trust that are treated as assets disposed of by the individual, 60 months) before:

   (1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or
   (2) The date a noninstitutionalized individual applies for medical assistance.

b. Transfer on or after February 8, 2006. For transfers made on or after February 8, 2006, the look-back date is the date that is 60 months before:

   (1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or
   (2) The date a noninstitutionalized individual applies for medical assistance.

75.23(3) Period of ineligibility. The number of months of ineligibility shall be equal to the total cumulative uncompensated value of all assets transferred by the individual (or the individual’s spouse) on or after the look-back date specified in subrule 75.23(2), divided by the statewide average private-pay rate for nursing facility services at the time of application. The department shall determine the average statewide cost to a private-pay resident for nursing facilities and update the cost annually. Current average statewide costs shall be published on the department’s website.

75.23(4) Reduction of period of ineligibility. The number of months of ineligibility otherwise determined with respect to the disposal of an asset shall be reduced by the months of ineligibility applicable to the individual prior to a change in institutional status.
75.23(5) Exceptions. An individual shall not be ineligible for medical assistance, under this rule, to the extent that:
   a. The assets transferred were a home and title to the home was transferred to either:
      (1) A spouse of the individual.
      (2) A child of the individual who is under the age of 21 or is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c.
      (3) A sibling of the individual who has an equity interest in the home and who was residing in the individual’s home for a period of at least one year immediately before the individual became institutionalized.
      (4) A son or daughter of the individual who was residing in the individual’s home for a period of at least two years immediately before the date of institutionalization and who provided care to the individual which permitted the individual to reside at home rather than in an institution or facility.
   b. The assets were transferred:
      (1) To the individual’s spouse or to another for the sole benefit of the individual’s spouse.
      (2) From the individual’s spouse to another for the sole benefit of the individual’s spouse.
      (3) To a child of the individual who is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c or to a trust established solely for the benefit of such a child.
      (4) To a trust established solely for the benefit of an individual under 65 years of age who is disabled as defined in 42 U.S.C. Section 1382c.
   c. A satisfactory showing is made that one of the following is true:
      (1) The individual intended to dispose of the assets either at fair market value, or for other valuable consideration.
      (2) The assets were transferred exclusively for a purpose other than to qualify for medical assistance.
      (3) All assets transferred for less than fair market value have been returned to the individual.
   d. The denial of eligibility would work an undue hardship. Undue hardship shall exist only when all of the following conditions are met:
      (1) Application of the transfer of asset penalty would deprive the individual of medical care such that the individual’s health or life would be endangered or of food, clothing, shelter, or other necessities of life.
      (2) The person who transferred the resource or the person’s spouse has exhausted all means including legal remedies and consultation with an attorney to recover the resource.
      (3) The person’s remaining available resources (after the attribution for the community spouse) are less than the monthly statewide average cost of nursing facility services to a private pay resident, counting the value of all resources except for:
         1. The home if occupied by a dependent relative or if a licensed physician verifies that the person is expected to return home.
         2. Household goods.
         3. A vehicle required by the client for transportation.
         4. Funds for burial of $4,000 or less.
      Hardship will not be found if the resource was transferred to a person who was handling the financial affairs of the client or to the spouse or children of a person handling the financial affairs of the client unless the client demonstrates that payments cannot be obtained from the funds of the person who handled the financial affairs to pay for long-term care services.
   75.23(6) Assets held in common. In the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset, or the affected portion of the asset, shall be considered to be transferred by the individual when any action is taken, either by the individual or by any other person, that reduces or eliminates the individual’s ownership or control of the asset.
   75.23(7) Transfer by spouse. In the case of a transfer by a spouse of an individual which results in a period of ineligibility for medical assistance under the state plan for the individual, the period of ineligibility shall be apportioned between the individual and the individual’s spouse if the spouse
otherwise becomes eligible for medical assistance under the state plan. The remaining penalty period shall be evenly divided on a monthly basis, with any remaining month of penalty (prorated as a half month to each spouse) applied to the spouse who initiated the transfer action.

If a spouse subsequently dies prior to the end of the penalty period, the remaining penalty period shall be applied to the surviving spouse’s period of ineligibility.

75.23(8) Definitions. In this rule the following definitions apply:

“Assets” shall include all income and resources of the individual and the individual’s spouse, including any income or resources which the individual or the individual’s spouse is entitled to but does not receive because of action by:

1. The individual or the individual’s spouse.
2. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual’s spouse.
3. Any person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual’s spouse.

“Income” shall be defined by 42 U.S.C. Section 1382a.

“Institutionalized individual” shall mean an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility or who is eligible for home- and community-based waiver services.

“Resources” shall be defined by 42 U.S.C. Section 1382b without regard (in the case of an institutionalized individual) to the exclusion of the home and land appertaining thereto.

“Transfer or disposal of assets” means any transfer or assignment of any legal or equitable interest in any asset as defined above, including:

1. Giving away or selling an interest in an asset;
2. Placing an interest in an asset in a trust that is not available to the grantor (see 75.24(2)”b”(2));
3. Removing or eliminating an interest in a jointly owned asset in favor of other owners;
4. Disclaiming an inheritance of any property, interest, or right pursuant to Iowa Code section 633.704 on or after July 1, 2000 (see Iowa Code section 249A.3(11)”c”);
5. Failure to take a share of an estate as a surviving spouse (also known as “taking against a will”) on or after July 1, 2000, to the extent that the value received by taking against the will would have exceeded the value of the inheritance received under the will (see Iowa Code section 249A.3(11)”d”); or
6. Transferring or disclaiming the right to income not yet received.

75.23(9) Purchase of annuities. Funds used to purchase an annuity for more than its fair market value shall be treated as assets transferred for less than fair market value regardless of when the annuity was purchased or whether the conditions described in this subrule were met.

a. The entire amount used to purchase an annuity on or after February 8, 2006, with a Medicaid applicant or member as the annuitant shall be treated as assets transferred for less than fair market value unless the annuity meets one of the conditions described in paragraph 75.23(9)”b” and also meets the condition described in paragraph 75.23(9)”c.”

b. To be exempted from treatment as an asset transferred at less than fair market value, an annuity described in paragraph 75.23(9)”a” must meet one of the following conditions:

1. The annuity is an annuity described in Subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986.
2. The annuity is purchased with proceeds from:
   1. An account or trust described in Subsection (b), (c), or (p) of Section 408 of the United States Internal Revenue Code of 1986;
   2. A simplified employee pension (within the meaning of Section 408(k) of the United States Internal Revenue Code of 1986); or
3. The annuity:
   1. Is irrevocable and nonassignable;
2. Is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration); and
3. Provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.
   c. To be exempted from treatment as an asset transferred at less than fair market value, an annuity described in paragraph 75.23(9) “a” must have Iowa named as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant or the annuitant’s spouse, if either is institutionalized. Iowa may be named either:
      (1) In the first position; or
      (2) In the second position after the spouse or minor or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.
   d. The entire amount used to purchase an annuity on or after February 8, 2006, with the spouse of a Medicaid applicant or member as the annuitant shall be treated as assets transferred for less than fair market value unless Iowa is named as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant or the annuitant’s spouse, if either is institutionalized. Iowa may be named either:
      (1) In the first position; or
      (2) In the second position after the spouse or minor or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

**75.23(10) Purchase of promissory notes, loans, or mortgages.**
   a. Funds used to purchase a promissory note, loan, or mortgage after February 8, 2006, shall be treated as assets transferred for less than fair market value in the amount of the outstanding balance due on the note, loan, or mortgage as of the date of the individual’s application for medical assistance for services described in 75.23(1), unless the note, loan, or mortgage meets all of the following conditions:
      (1) The note, loan, or mortgage has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration).
      (2) The note, loan, or mortgage provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.
      (3) The note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.
   b. Funds used to purchase a promissory note, loan, or mortgage for less than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:
      (1) The note, loan, or mortgage was purchased before February 8, 2006; or
      (2) The note, loan, or mortgage was purchased on or after February 8, 2006, and the conditions described in 75.23(9) “a” were met.

**75.23(11) Purchase of life estates.**
   a. The entire amount used to purchase a life estate in another individual’s home after February 8, 2006, shall be treated as assets transferred for less than fair market value, unless the purchaser resides in the home for at least one year after the date of the purchase.
   b. Funds used to purchase a life estate in another individual’s home for more than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:
      (1) The life estate was purchased before February 8, 2006; or
      (2) The life estate was purchased on or after February 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

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

[ARC 7834B, IAB 6/3/09, effective 7/8/09; ARC 8444B, IAB 1/13/10, effective 3/1/10; ARC 8898B, IAB 6/30/10, effective 7/1/10; ARC 9404B, IAB 5/9/11, effective 5/1/11; ARC 9582B, IAB 6/29/11, effective 7/1/11; ARC 0192C, IAB 7/11/12, effective 7/1/12; ARC 0821C, IAB 7/10/13, effective 7/1/13; ARC 1484C, IAB 6/11/14, effective 7/1/14; ARC 2027C, IAB 6/10/15, effective 7/1/15; ARC 2605C, IAB 7/6/16, effective 7/1/16; ARC 3183C, IAB 7/5/17, effective 7/1/17; ARC 3869C, IAB 7/4/18, effective 7/1/18; ARC 4572C, IAB 7/31/19, effective 7/11/19]
441—75.24(249A) Treatment of trusts established after August 10, 1993. For purposes of determining an individual’s eligibility for, or the amount of, medical assistance benefits, trusts established after August 10, 1993, (except for trusts specified in 75.24(3)) shall be treated in accordance with 75.24(2).

75.24(1) Establishment of trust.
   a. For the purposes of this rule, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if any of the following individuals established the trust other than by will: the individual, the individual’s spouse, a person (including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual’s spouse), or a person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual’s spouse.
   b. The term “assets,” with respect to an individual, includes all income and resources of the individual and of the individual’s spouse, including any income or resources which the individual or the individual’s spouse is entitled to but does not receive because of action by the individual or the individual’s spouse, by a person (including a court or administrative body, with legal authority to act in place of or on behalf of the individual’s spouse), or by any person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual’s spouse.
   c. In the case of a trust, the principal of which includes assets of an individual and assets of any other person or persons, the provisions of this rule shall apply to the portion of the trust attributable to the individual.
   d. This rule shall apply without regard to:
      (1) The purposes for which a trust is established.
      (2) Whether the trustees have or exercise any discretion under the trust.
      (3) Any restrictions on when or whether distribution may be made for the trust.
      (4) Any restriction on the use of distributions from the trust.
   e. The term “trust” includes any legal instrument or device that is similar to a trust, including a conservatorship.

75.24(2) Treatment of revocable and irrevocable trusts.
   a. In the case of a revocable trust:
      (1) The principal of the trust shall be considered an available resource.
      (2) Payments from the trust to or for the benefit of the individual shall be considered income of the individual.
      (3) Any other payments from the trust shall be considered assets disposed of by the individual, subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.
   b. In the case of an irrevocable trust:
      (1) If there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the principal from which, or the income on the principal from which, payment to the individual could be made shall be considered an available resource to the individual and payments from that principal or income to or for the benefit of the individual shall be considered income to the individual. Payments for any other purpose shall be considered a transfer of assets by the individual subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.
      (2) Any portion of the trust from which, or any income on the principal from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed of by the individual subject to the penalties specified at 75.23(3) and 441—Chapter 89. The value of the trust shall be determined for this purpose by including the amount of any payments made from this portion of the trust after this date.

75.24(3) Exceptions. This rule shall not apply to any of the following trusts:
   a. A trust containing the assets of an individual under the age of 65 who is disabled (as defined in Section 1614(a)(3) of the Social Security Act) and which is established for the benefit of the individual by a parent, grandparent, legal guardian of the individual, or a court if the state will receive all amounts
remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual.

b. A trust established for the benefit of an individual if the trust is composed only of pension, social security, and other income to the individual (and accumulated income of the trust), and the state will receive all amounts remaining in the trust upon the death of the individual up to the amount equal to the total medical assistance paid on behalf of the individual. For disposition of trust amounts pursuant to Iowa Code sections 633C.1 to 633C.5, the average statewide charges and Medicaid rates are updated annually and shall be published on the department’s website.

c. A trust containing the assets of an individual who is disabled (as defined in 1614(a)(3) of the Social Security Act) that meets the following conditions:

(1) The trust is established and managed by a nonprofit association.

(2) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

(3) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in 1614(a)(3) of the Social Security Act) by the parent, grandparent, or legal guardian of the individuals, by the individuals or by a court.

(4) To the extent that amounts remaining in the beneficiary’s account upon death of the beneficiary are not retained by the trust, the trust pays to the state from the remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary.

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

441—75.25(249A) Definitions. Unless otherwise specified, the definitions in this rule shall apply to 441—Chapters 75 through 85 and 88.

“**Aged**” shall mean a person 65 years of age or older.

“**Applicant**” shall mean a person who is requesting assistance, including recertification under the medically needy program, on the person’s own behalf or on behalf of another person. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

“**Blind**” shall mean a person with central visual acuity of 20/200 or less in the better eye with use of corrective lens or visual field restriction to 20 degrees or less.

“**Break in assistance**” for medically needy shall mean the lapse of more than three months from the end of the medically needy certification period to the beginning of the next current certification period.

“**Central office**” shall mean the state administrative office of the department of human services.

“**Certification period**” for medically needy shall mean the period of time not to exceed two consecutive months in which a person is conditionally eligible.

“**Client**” shall mean all of the following:

1. A Medicaid applicant;
2. A Medicaid member;
3. A person who is conditionally eligible for Medicaid; and
4. A person whose income or assets are considered in determining eligibility for an applicant or member.

“**CMAP-related medically needy**” shall mean those individuals under the age of 21 who would be eligible for the child medical assistance program except for excess income or resources.

“**Community spouse**” shall mean a spouse of an institutionalized spouse for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

“**Conditionally eligible**” shall mean that a person has completed the application process and has been assigned a medically needy certification period and spenddown amount but has not met the spenddown
amount for the certification period or has been assigned a monthly premium but has not yet paid the 
premium for that month.

“Coverage group” shall mean a group of persons who meet certain common eligibility requirements.

“Department” shall mean the Iowa department of human services.

“Disabled” shall mean a person who is unable to engage in any substantial gainful activity by reason of
any medically determinable physical or mental impairment which has lasted or is expected to last for
a continuous period of not less than 12 months from the date of application.

“FMAP-related medically needy” shall mean those persons who would be eligible for the family
medical assistance program except for excess income or resources.

“Health insurance” shall mean protection which provides payment of benefits for covered sickness
or injury.

“Incurred medical expenses” for medically needy shall mean (1) medical bills paid by a client,
responsible relative, or state or political subdivision program other than Medicaid during the retroactive
certification period or the certification period, or (2) unpaid medical expenses for which the client or
responsible relative remains obligated.

“Institutionalized person” shall mean a person who is an inpatient in a nursing facility or a
Medicare-certified skilled nursing facility, who is an inpatient in a medical institution and for whom
payment is made based on a level of care provided in a nursing facility, or who is a person described in
75.1(18) for the purposes of rule 441—75.5(249A).

“Institutionalized spouse” shall mean a married person living in a medical institution, or nursing
facility, or home- and community-based waiver setting who is likely to remain living in these
circumstances for at least 30 consecutive days, and whose spouse is not in a medical institution or
nursing facility for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

“Local office” shall mean the county office of the department of human services or the mental health
institute or hospital school.

“Medically needy income level (MNIL)” shall mean 133 1/3 percent of the schedule of basic needs
based on family size. (See subrule 75.58(2).)

“Member” shall mean a person who has been determined eligible for medical assistance under rule
441—75.1(249A). For the medically needy program, “member” shall mean a medically needy person
who has income at or less than the medically needy income level (MNIL) or who has reduced countable
income to the MNIL during the certification period through spenddown. “Member” may be used
interchangeably with “recipient.” This definition does not apply to the phrase “household member.”

“Necessary medical and remedial services” for medically needy shall mean medical services
recognized by law which are currently covered under the Iowa Medicaid program.

“Noncovered Medicaid services” for medically needy shall mean medical services that are not
covered under Medicaid because the provider was not enrolled in Medicaid, the services are ones
which are otherwise not covered under Medicaid, the bill is for a responsible relative who is not in the
Medicaid-eligible group or the bill is for services delivered before the start of a certification period.

“Nursing facility services” shall mean the level of care provided in a medical institution licensed for
nursing services or skilled nursing services for the purposes of rule 441—75.23(249A).

“Obligated medical expense” for medically needy shall mean a medical expense for which the client
or responsible relative continues to be legally liable.

“Ongoing eligibility” for medically needy shall mean that eligibility continues for an SSI-related,
CMAP-related, or FMAP-related medically needy person with a zero spenddown.

“Pay and chase” shall mean that the state pays the total amount allowed under the agency’s payment
schedule and then seeks reimbursement from the liable third party. The pay and chase provision applies
to Medicaid claims for prenatal care, for preventive pediatric services, and for all services provided to a
person for whom there is court-ordered medical support.

“Payee” refers to an SSI payee as defined in Iowa Code subsections 633.33(7) and 633.3(20).

“Recertification” in the medically needy coverage group shall mean establishing a new certification
period when the previous period has expired and there has not been a break in assistance.
“Recipient” shall mean a person who is receiving assistance including receiving assistance for another person.

“Responsible relative” for medically needy shall mean a spouse, parent, or stepparent living in the household of the client.

“Retroactive certification period” for medically needy shall mean one, two, or three calendar months prior to the date of application, as provided in 441—subrule 76.13(3). The retroactive certification period begins with the first month Medicaid-covered services were received and continues to the end of the month immediately prior to the month of application.

“Retroactive period” shall mean the three or fewer calendar months immediately preceding the month in which an application is filed, pursuant to 441—subrule 76.13(3).

“Settlement” shall mean the process by which a medically needy person obligates excess income for allowable medical expenses to reduce income to the appropriate MNIL.

“SSI-related” shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except that income shall be considered prospectively.

“SSI-related medically needy” shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except for income or resources.

“Supply” shall mean the requested information is received by the department by the specified due date.

“Transfer of assets” shall mean transfer of resources or income for less than fair market value for the purposes of rule 441—75.23(249A). For example, a transfer of resources or income could include establishing a trust, contributing to a charity, removing a name from a resource or income, or reducing ownership interest in a resource or income.

“Unborn child” shall include an unborn child during the entire term of pregnancy.

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

[ARC 7935B, IAB 7/1/09, effective 9/1/09; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3353C, IAB 10/11/17, effective 10/1/17; ARC 3549C, IAB 1/3/18, effective 2/7/18; ARC 4208C, IAB 1/2/19, effective 2/6/19]

441—75.26(249A) References to the family investment program. Rescinded IAB 10/8/97, effective 12/1/97.

441—75.27(249A) AIDS/HIV settlement payments. The following payments are exempt as income and resources when determining eligibility for or the amount of Medicaid benefits under any coverage group if the payments are kept in a separate, identifiable account:

75.27(1) Class settlement payments. Payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corporation, et al., 96-C-5024 (N.D. Ill.) are exempt.

75.27(2) Other settlement payments. Payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement referred to in subrule 75.27(1) and that is signed by all affected parties in the cases on or before the later of December 31, 1997, or the date that is 270 days after the date on which the release is first sent to the person (or the legal representative of the person) to whom payment is to be made are exempt.

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

441—75.28(249A) Recovery.

75.28(1) Definitions.

“Administrative overpayment” means medical assistance incorrectly paid to or for the client because of continuing assistance during the appeal process or allowing a deduction for the Medicare Part B premium in determining client participation while the department arranges to pay the Medicare premium directly.

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

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

“Client” means a current or former Medicaid member.

“Client error” means medical assistance incorrectly paid to or for the client because the client or client’s representative failed to disclose information, or gave false or misleading statements, oral or written, regarding the client’s income, resources, or other eligibility and benefit factors. “Client error” also means assistance incorrectly paid to or for the client because of failure by the client or client’s representative to timely report as defined in rule 441—76.15(249A).

“Department” means the department of human services.

“Premiums paid for medical assistance” means monthly premiums assessed to a member or household for Medicaid, IowaCare or the Iowa Health and Wellness Plan coverage.

75.28(2) Amount subject to recovery. The department shall recover from a client all Medicaid funds incorrectly expended to or on behalf of the client and all unpaid premiums assessed by the department for medical assistance. The incorrect expenditures or unpaid premiums may result from client or agency error or administrative overpayment.

75.28(3) Notification. All clients shall be promptly notified on Form 470-2891, Notice of Medical Assistance Overpayment, when it is determined that assistance was incorrectly expended or when assessed premiums are unpaid.

a. Notification of incorrect expenditures shall include:
   (1) For whom assistance was paid;
   (2) The period during which assistance was incorrectly paid;
   (3) The amount of assistance subject to recovery; and
   (4) The reason for the incorrect expenditure.

b. Notification of unpaid premiums shall include:
   (1) The amount of the premium; and
   (2) The month covered by the medical assistance premium.

75.28(4) Source of recovery. Recovery shall be made from the client or from parents of children under the age of 21 when the parents completed the application and had responsibility for reporting changes. Recovery may come from income, resources, the estate, income tax refunds, and lottery winnings of the client.

75.28(5) Repayment. The repayment of incorrectly expended Medicaid funds shall be made to the department. However, repayment of funds incorrectly paid to a nursing facility, a Medicare-certified skilled nursing facility, a psychiatric medical institution for children, an intermediate care facility for persons with an intellectual disability, or mental health institute enrolled as an inpatient psychiatric facility may be made by the client to the facility. The department shall then recover the funds from the facility through a vendor adjustment.

75.28(6) Appeals. The client shall have the right to appeal the amount of funds subject to recovery under the provisions of 441—Chapter 7.

75.28(7) Estate recovery. Medical assistance, including the amount the state paid to a managed care organization (MCO) for provision of medical services, also called capitation fees, is subject to recovery from the estate of a Medicaid member, the estate of the member’s surviving spouse, or the estate of the member’s surviving child as provided in this subrule. Effective January 1, 2010, medical assistance that has been paid for Medicare cost sharing or for benefits described in Section 1902(a)(10)(E) of the Social Security Act is not subject to recovery. All assets included in the estate of the member, the surviving spouse, or the surviving child are subject to probate for the purposes of medical assistance estate recovery pursuant to Iowa Code section 249A.53(2)“d.” The classification of the debt is defined at Iowa Code section 633.425(7).

a. Definitions.
“Capitated payment/rate” means a monthly payment to the contractor on behalf of each member for the provision of health services under the contract. Payment is made regardless of whether the member receives services during the month.

“Estate.” For the purpose of this subrule, the “estate” of a Medicaid member, a surviving spouse, or a surviving child shall include all real property, personal property, or any other asset in which the member, spouse, or surviving child had any legal title or interest at the time of death, or at the time a child reaches the age of 21, to the extent of that interest. An estate includes, but is not limited to, interest in jointly held property, retained life estates, and interests in trusts.

“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.

b. Debt due for member 55 years of age or older. Receipt of medical assistance when a member is 55 years of age or older creates a debt due to the department from the member’s estate upon the member’s death for all medical assistance provided on the member’s behalf on or after July 1, 1994.

c. Debt due for member under the age of 55 in a medical institution.

(1) Receipt of medical assistance creates a debt due to the department from the member’s estate upon the member’s death for all medical assistance provided on the member’s behalf on or after July 1, 1994, when the member:
   1. Is under the age of 55; and
   2. Is a resident of a nursing facility, an intermediate care facility for persons with an intellectual disability, or a mental health institute; and
   3. Cannot reasonably be expected to be discharged and return home.

(2) If the member is discharged from the facility and returns home before staying six consecutive months, no debt will be assessed for medical assistance payments made on the member’s behalf for the time in the institution.

(3) If the member remains in the facility for six consecutive months or longer or dies before staying six consecutive months, the department shall presume that the member cannot or could not reasonably be expected to be discharged and return home and a debt due shall be established. The department shall notify the member of the presumption and the establishment of a debt due.

d. Request for a determination of ability to return home. Upon receipt of a notice of the establishment of a debt due based on the presumption that the member cannot return home, the member or someone acting on the member’s behalf may request that the department determine whether the member can or could have reasonably been expected to return home.

(1) When a written request is made within 30 days of the notice that a debt due will be established, no debt due shall be established until the department has made a decision on the member’s ability to return home. If the determination is that there is or was no ability to return home, a debt due shall be established for all medical assistance as of the date of entry into the institution.

(2) When a written request is made more than 30 days after the notice that a debt due will be established, a debt due will be established for medical assistance provided before the request even if the determination is that the member can or could have returned home.

e. Determination of ability to return home. When the member or someone acting on the member’s behalf requests that the department determine if the member can or could have returned home, the determination shall be made by the Iowa Medicaid enterprise (IME) medical services unit.

(1) The IME medical services unit cannot make a determination until the member has been in an institution at least six months or after the death of the member, whichever is earlier. The IME medical services unit will notify the member or the member’s representative and the department of the determination.

(2) If the determination is that the member can or could return home, the IME medical services unit shall establish the date the return is expected or could have been expected to occur.

(3) If the determination is that the member cannot or could not return home, a debt due will be established unless the member or the member’s representative asks for a reconsideration of the decision.
The IME medical services unit will notify the member or the member’s representative and the department of the reconsideration decision.

4. If the reconsideration decision is that the member cannot or could not return home, a debt due will be established against the member unless the decision is appealed pursuant to 441—Chapter 7. The appeal decision will determine the final outcome for the establishment of a debt due and the period when the debt is established.

f. **Debt collection.**

1. A nursing facility participating in the medical assistance program shall notify the IME revenue collection unit upon the death of a member residing in the facility by submitting Form 470-4331, Estate Recovery Program Nursing Home Referral.

2. Upon receipt of Form 470-4331 or a report of a member’s death through other means, the IME revenue collection unit will use Form 470-4339, Medical Assistance Debt Response, to request a statement of the member’s assets from the member’s personal representative. The representative shall sign and return Form 470-4339 indicating whether assets remain and, if so, what the assets are and what higher priority expenses exist. **EXCEPTION:** The procedures in this subparagraph are not necessary when a probate estate has been opened, because probate procedures provide for an inventory, an accounting, and a final report of the estate.

g. **Waiving the collection of the debt.**

1. The department shall waive the collection of the debt created under this subrule from the estate of the member to the extent that collection of the debt would result in either of the following:

   a. Reduction in the amount received from the member’s estate by a surviving spouse or by a surviving child who is under the age of 21, blind, or permanently and totally disabled at the time of the member’s death.

   b. Creation of an undue hardship for the person seeking a waiver of estate recovery. Undue hardship exists when total household income is less than 200 percent of the poverty level for a household of the same size, total household resources do not exceed $10,000, and application of estate recovery would result in deprivation of food, clothing, shelter, or medical care such that life or health would be endangered. For this purpose, “income” and “resources” shall be defined as being under the family investment program.

2. To apply for a waiver of estate recovery due to undue hardship, the person shall provide a written statement and supporting verification to the department within 30 days of the notice of estate recovery pursuant to Iowa Code section 249A.53(2).

3. The department shall determine whether undue hardship exists on a case-by-case basis. Appeals of adverse decisions regarding an undue hardship determination may be filed in accordance with 441—Chapter 7.

h. **Amount waived.** If collection of all or part of a debt is waived pursuant to paragraph 75.28(7) “g.,” to the extent that the person received the member’s estate, the amount waived shall be a debt due from the following:

1. The estate of the member’s surviving spouse, upon the death of the spouse.

2. The estate of the member’s surviving child who is blind or has a disability, upon the death of the child.

3. A surviving child who was under 21 years of age at the time of the member’s death, when the child reaches the age of 21.

4. The estate of a surviving child who was under 21 years of age at the time of the member’s death, if the child dies before reaching the age of 21.

5. The hardship waiver recipient, when the hardship no longer exists.

6. The estate of the recipient of the undue hardship waiver, at the time of death of the hardship waiver recipient.

i. **Impact of asset disregard on debt due.** The estate of a member who is eligible for medical assistance under subrule 75.5(5) shall not be subject to a claim for medical assistance paid on the member’s behalf up to the amount of the assets disregarded by asset disregard. Medical assistance paid
on behalf of the member before these conditions shall be recovered from the estate, regardless of the membership’s having purchased precertified or approved insurance.

j. Interest on debt. Interest shall accrue on a debt due under this subrule at the rate provided pursuant to Iowa Code section 535.3, beginning six months after the death of a Medicaid member, the surviving spouse, or the surviving child, or upon the child’s reaching the age of 21.

k. Reimbursement to county. If a county reimburses the department for medical assistance provided under this subrule and the amount of medical assistance is subsequently repaid through a medical assistance income trust or a medical assistance special needs trust as defined in Iowa Code chapter 633C, the department shall reimburse the county on a proportionate basis.

[ARC 1134C, IAB 10/30/13, effective 10/2/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—75.29(249A) Investigation by quality control or the department of inspections and appeals. An applicant or member shall cooperate with the department when the applicant’s or member’s case is selected by quality control or the department of inspections and appeals for verification of eligibility unless the investigation revolves solely around the circumstances of a person whose income and resources do not affect medical assistance eligibility. (See department of inspections and appeals rules in 481—Chapter 72.) Failure to cooperate shall serve as a basis for denial of an application or cancellation of medical assistance unless the Medicaid eligibility is determined by the Social Security Administration. Once a person’s eligibility is denied or canceled for failure to cooperate, the person may reapply but shall not be determined eligible until cooperation occurs.

[ARC 1134C, IAB 10/30/13, effective 10/2/13]

441—75.30(249A) Member lock-in. Rescinded ARC 2361C, IAB 1/6/16, effective 1/1/16.

441—75.31 to 75.49 Reserved.

DIVISION II
ELIGIBILITY FACTORS SPECIFIC TO COVERAGE GROUPS RELATED TO THE FAMILY MEDICAL ASSISTANCE PROGRAM (FMAP)

441—75.50(249A) Definitions. The following definitions apply to this division in addition to the definitions in rule 441—75.25(249A).

“Applicant” shall mean a person who is requesting assistance on the person’s own behalf or on behalf of another person, including recertification under the medically needy program. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

“Application period” means the months beginning with the month in which the application is considered to be filed, through and including the month in which an eligibility determination is made.

“Assistance unit” includes any person whose income is considered when determining eligibility.

“Bona fide offer” means an actual or genuine offer which includes a specific wage or a training opportunity at a specified place when used to determine whether the parent has refused an offer of training or employment.

“Central office” shall mean the state administrative office of the department of human services.

“Change in income” means a permanent change in hours worked or rate of pay, any change in the amount of unearned income, or the beginning or ending of any income.

“Change in work expenses” means a permanent change in the cost of dependent care or the beginning or ending of dependent care.

“Department” shall mean the Iowa department of human services.

“Dependent” means an individual who can be claimed by another individual as a dependent for federal income tax purposes.

“Dependent child” or “dependent children” means a child or children who meet the nonfinancial eligibility requirements of the applicable FMAP-related coverage group.
“Income in-kind” is any gain or benefit which is not in the form of money payable directly to the eligible group including nonmonetary benefits, such as meals, clothing, and vendor payments. Vendor payments are money payments which are paid to a third party and not to the eligible group.

“Initial two months” means the first two consecutive months for which eligibility is granted.

“Medical institution,” when used in this division, shall mean a facility which is organized to provide medical care, including nursing and convalescent care, in accordance with accepted standards as authorized by state law and as evidenced by the facility’s license. A medical institution may be public or private. Medical institutions include the following:

1. Hospitals.
2. Extended care facilities (skilled nursing).
3. Intermediate care facilities.
4. Mental health institutions.
5. Hospital schools.

“Needy specified relative” means a nonparental specified relative, listed in 75.55(1), who meets all the eligibility requirements of the FMAP coverage group, listed in 75.1(14).

“Nonrecurring lump sum unearned income” means a payment in the nature of a windfall, for example, an inheritance, an insurance settlement for pain and suffering, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits such as social security, job insurance or workers’ compensation.

“Parent” means a legally recognized parent, including an adoptive parent, or a biological father if there is no legally recognized father.

“Prospective budgeting” means the determination of eligibility and the amount of assistance for a calendar month based on the best estimate of income and circumstances which will exist in that calendar month.

“Recipient” means a person for whom Medicaid is received as well as parents living in the home with the eligible children and other specified relatives as defined in subrule 75.55(1) who are receiving Medicaid for the children. Unless otherwise specified, a person is not a recipient for any month in which the assistance issued for that person is subject to recoupment because the person was ineligible.

“Schedule of needs” means the total needs of a group as determined by the schedule of living costs, described at subrule 75.58(2).

“Stepparent” means a person who is not the parent of the dependent child, but is the legal spouse of the dependent child’s parent by ceremonial or common-law marriage.

“Unborn child” means an unborn child during the entire term of pregnancy.

“Uniformed service” means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

441—75.51(249A) Reinstatement of eligibility. Rescinded IAB 2/10/10, effective 3/1/10.

441—75.52(249A) Continuing eligibility.

75.52(1) Reviews. Eligibility factors shall be reviewed at least annually for the FMAP-related programs. Reviews shall be conducted using information contained in and verification supplied with the review form specified in subrule 75.52(3).

75.52(2) Additional reviews. A redetermination of specific eligibility factors shall be made when:

a. The member reports a change in circumstances (for example, a change in income, as defined at rule 441—75.50(249A)), or

b. A change in the member’s circumstances comes to the attention of a staff member.

75.52(3) Forms.

a. Information for the annual review shall be submitted on Form 470-2881, 470-2881(M), 470-2881(S), or 470-2881(MS), Review/Recertification Eligibility Document (RRED), with the following exceptions:
(1) When the client has completed Form 470-0462 or 470-0466 (Spanish), Health and Financial Support Application, for another purpose, this form may be used as the review document for the annual review.

(2) Information for recertification of family medical assistance-related medically needy shall be submitted on Form 470-3118 or 470-3118(S), Medicaid Review.

b. The department shall supply the review form to the client as needed, or upon request, and shall pay the cost of postage to return the form.

(1) When the review form is issued in the department’s regular end-of-month mailing, the client shall return the completed form to the department by the fifth calendar day of the following month.

(2) When the review form is not issued in the department’s regular end-of-month mailing, the client shall return the completed form to the department by the seventh day after the date the form is mailed by the department.

(3) A copy of a review form received by fax or electronically shall have the same effect as an original form.

c. The review information for foster children or children in subsidized adoption or subsidized guardianship shall be submitted on Form 470-2914, Foster Care, Adoption, and Guardianship Medicaid Review.

75.52(4) Client responsibilities. For the purposes of this subrule, “clients” shall include persons who received assistance subject to recoupment because the persons were ineligible.

a. The client shall cooperate by giving complete and accurate information needed to establish eligibility.

b. The client shall complete the required review form when requested by the department in accordance with subrule 75.52(3). If the department does not receive a completed form, assistance shall be canceled. A completed form is one that has all items answered, is signed, is dated, and is accompanied by verification as required in paragraphs 75.57(1)“f” and 75.57(2)“l.”

c. The client shall report any change in the following circumstances at the annual review or upon the addition of an individual to the eligible group:

(1) Income from all sources, including any change in care expenses.
(2) Resources.
(3) Members of the household.
(4) School attendance.
(5) A stepparent recovering from an incapacity.
(6) Change of mailing or living address.
(7) Payment of child support.
(8) Receipt of a social security number.
(9) Payment for child support, alimony, or dependents as defined in paragraph 75.57(8)“b.”
(10) Health insurance premiums or coverage.

d. All clients shall timely report any change in the following circumstances at any time:

(1) Members of the household.
(2) Change of mailing or living address.
(3) Sources of income.
(4) Health insurance premiums or coverage.

e. Clients described at subrule 75.1(35) shall also timely report any change in income from any source and any change in care expenses at any time.

f. A report shall be considered timely when made within ten days from the date:

(1) A person enters or leaves the household.
(2) The mailing or living address changes.
(3) A source of income changes.
(4) A health insurance premium or coverage change is effective.
(5) Of any change in income.
(6) Of any change in care expenses.
g. When a change is not reported as required in paragraphs 75.52(4)“c” through “e,” any excess Medicaid paid shall be subject to recovery.

h. When a change in any circumstance is reported, its effect on eligibility shall be evaluated and eligibility shall be redetermined, if appropriate, regardless of whether the report of the change was required in paragraphs 75.52(4)“c” through “e.”

75.52(5) Effective date. After assistance has been approved, eligibility for continuing assistance shall be effective as of the first of each month. Any change affecting eligibility reported during a month shall be effective the first day of the next calendar month, subject to timely notice requirements at rule 441—7.6(217) for any adverse actions.

a. When the change creates ineligibility, eligibility under the current coverage group shall be canceled and an automatic redetermination of eligibility shall be completed in accordance with rule 441—76.11(249A).

b. Rescinded IAB 10/4/00, effective 10/1/00.

c. When an individual included in the eligible group becomes ineligible, that individual’s Medicaid shall be canceled effective the first of the next month unless the action must be delayed due to timely notice requirements at rule 441—7.6(217).

[ARC 8260B, IAB 11/4/09, effective 1/1/10; ARC 8500B, IAB 2/10/10, effective 3/1/10]

441—75.53(249A) Iowa residency policies specific to FMAP and FMAP-related coverage groups. Notwithstanding the provisions of rule 441—75.10(249A), the following rules shall apply when determining eligibility for persons under FMAP or FMAP-related coverage groups.

75.53(1) Definition of resident. A resident of Iowa is one:

a. Who is living in Iowa voluntarily with the intention of making that person’s home there and not for a temporary purpose. A child is a resident of Iowa when living there on other than a temporary basis. Residence may not depend upon the reason for which the individual entered the state, except insofar as it may bear upon whether the individual is there voluntarily or for a temporary purpose; or

b. Who, at the time of application, is living in Iowa, is not receiving assistance from another state, and entered Iowa with a job commitment or seeking employment in Iowa, whether or not currently employed. Under this definition the child is a resident of the state in which the specified relative is a resident.

75.53(2) Retention of residence. Residence is retained until abandoned. Temporary absence from Iowa, with subsequent returns to Iowa, or intent to return when the purposes of the absence have been accomplished does not interrupt continuity of residence.

75.53(3) Suitability of home. The home shall be deemed suitable until the court has ruled it unsuitable and, as a result of such action, the child has been removed from the home.

75.53(4) Absence from the home.

a. An individual who is absent from the home shall not be included in the eligible group, except as described in paragraph “b.”

(1) A parent who is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday is considered absent from the home.

(2) A parent whose absence from the home is due solely to a pattern of employment is not considered to be absent.

(3) A parent whose absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States is considered absent from the home. “Uniformed service” means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

b. The needs of an individual who is temporarily out of the home are included in the eligible group if otherwise eligible. A temporary absence exists in the following circumstances:

(1) An individual is anticipated to be in the medical institution for less than a year, as verified by a physician’s statement. Failure to return within one year from the date of entry into the medical institution will result in the individual’s needs being removed from the eligible group.
(2) A child is out of the home to secure education or training as defined in paragraph 75.54(1) “b” as long as the child remains a dependent.

(3) A parent or specified relative is temporarily out of the home to secure education or training and was in the eligible group before leaving the home to secure education or training. For this purpose, “education or training” means any academic or vocational training program that prepares a person for a specific professional or vocational area of employment.

(4) An individual is out of the home for reasons other than reasons in subparagraphs 75.53(4) “b” (1) through (3) and intends to return to the home within three months. Failure to return within three months from the date the individual left the home will result in the individual’s needs being removed from the eligible group.

[ARÀ 0579C, IAB 2/6/13, effective 4/1/13]

441—75.54(249A) Eligibility factors specific to child.

75.54(1) Age. Unless otherwise specified at rule 441—75.1(249A), Medicaid shall be available to a needy child under the age of 18 years without regard to school attendance.

a. A child is eligible for the entire month in which the child’s eighteenth birthday occurs, unless the birthday falls on the first day of the month.

b. Medicaid shall also be available to a needy child aged 18 years who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and who is reasonably expected to complete the program before reaching the age of 19 if the following criteria are met.

(1) A child shall be considered attending school full-time when enrolled or accepted in a full-time (as certified by the school or institute attended) elementary, secondary or the equivalent level of vocational or technical school or training leading to a certificate or diploma. Correspondence school is not an allowable program of study.

(2) A child shall also be considered to be in regular attendance in months when the child is not attending because of an official school or training program vacation, illness, convalescence, or family emergency. A child meets the definition of regular school attendance until the child has been officially dropped from the school rolls.

(3) When a child’s education is temporarily interrupted pending adjustment of an education or training program, exemption shall be continued for a reasonable period of time to complete the adjustment.

75.54(2) Residing with a relative. The child shall be living in the home of one of the relatives specified in subrule 75.55(1). When the mother intends to place her child for adoption shortly after birth, the child shall be considered as living with the mother until the time custody is actually relinquished.

a. Living with relatives implies primarily the existence of a relationship involving an accepted responsibility on the part of the relative for the child’s welfare, including the sharing of a common household.

b. Home is the family setting maintained or in the process of being established as evidenced by the assumption and continuation of responsibility for the child by the relative.

75.54(3) Deprivation of parental care and support. Rescinded IAB 11/1/00, effective 1/1/01.

75.54(4) Continuous eligibility for children. Rescinded IAB 11/5/08, effective 11/1/08.

441—75.55(249A) Eligibility factors specific to specified relatives.

75.55(1) Specified relationship.

a. A child may be considered as meeting the requirement of living with a specified relative if the child’s home is with one of the following or with a spouse of the relative even though the marriage is terminated by death or divorce:

Father or adoptive father.

Mother or adoptive mother.

Grandfather or grandfather-in-law, meaning the subsequent husband of the child’s natural grandmother, i.e., stepgrandfather or adoptive grandfather.
Grandmother or grandmother-in-law, meaning the subsequent wife of the child’s natural grandfather, i.e., stepgrandmother or adoptive grandmother.
Great-grandfather or great-great-grandfather.
Great-grandmother or great-great-grandmother.
Stepfather, but not his parents.
Stepmother, but not her parents.
Brother, brother-of-half-blood, stepbrother, brother-in-law or adoptive brother.
Sister, sister-of-half-blood, stepsister, sister-in-law or adoptive sister.
Uncle or aunt, of whole or half blood.
Uncle-in-law or aunt-in-law.
Great uncle or great-great-uncle.
Great aunt or great-great-aunt.
First cousins, nephews, or nieces.

b. A relative of the putative father can qualify as a specified relative if the putative father has acknowledged paternity by the type of written evidence on which a prudent person would rely.

75.55(2) Liability of relatives. All appropriate steps shall be taken to secure support from legally liable persons on behalf of all persons in the eligible group, including the establishment of paternity as provided in rule 441—75.14(249A).

a. When necessary to establish eligibility, the department shall make the initial contact with the absent parent at the time of application. Subsequent contacts may be made by the child support recovery unit.

b. When contact with the family or other sources of information indicates that relatives other than parents and spouses of the eligible children are contributing toward the support of members of the eligible group, have contributed in the past, or are of such financial standing they might reasonably be expected to contribute, the department shall contact these persons to verify current contributions or arrange for contributions on a voluntary basis.

[ARC 8785B, IAB 6/2/10, effective 8/1/10]

441—75.56(249A) Resources.

75.56(1) Limitation. Unless otherwise specified, a client may have the following resources and be eligible for the family medical assistance program (FMAP) or FMAP-related programs. Any resource not specifically exempted shall be counted toward the applicable resource limit when determining eligibility for adults. All resources shall be disregarded when determining eligibility for children.

a. A homestead without regard to its value. A mobile home or similar shelter shall be considered as a homestead when it is occupied by the client. Temporary absence from the homestead with a defined purpose for the absence and with intent to return when the purpose of the absence has been accomplished shall not be considered to have altered the exempt status of the homestead. Except as described at paragraph 75.56(1)”n” or “o,” the net market value of any other real property shall be considered with personal property.

b. Household goods and personal effects without regard to their value. Personal effects are personal or intimate tangible belongings of an individual, especially those that are worn or carried on the person, which are maintained in one’s home, and include clothing, books, grooming aids, jewelry, hobby equipment, and similar items.

c. Life insurance which has no cash surrender value. The owner of the life insurance policy is the individual paying the premium on the policy with the right to change the policy as the individual sees fit.

d. One motor vehicle per household. If the household includes more than one adult or working teenaged child whose resources must be considered as described in subrule 75.56(2), an equity not to exceed a value of $3,000 in one additional motor vehicle shall be disregarded for each additional adult or working teenaged child.

(1) The disregard for an additional motor vehicle shall be allowed when a working teenager is temporarily absent from work.
(2) The equity value of any additional motor vehicle in excess of $3,000 shall be counted toward the resource limit in paragraph 75.56(1) “e.” When a motor vehicle is modified with special equipment for the handicapped, the special equipment shall not increase the value of the motor vehicle.

(3) Beginning July 1, 1994, and continuing in succeeding state fiscal years, the motor vehicle equity value to be disregarded shall be increased by the latest increase in the consumer price index for used vehicles during the previous state fiscal year.

e. A reserve of other property, real or personal, not to exceed $2,000 for applicant assistance units and $5,000 for member assistance units. EXCEPTION: Applicant assistance units that contain at least one person who was a Medicaid member in Iowa in the month before the month of application are subject to the $5,000 limit. Resources of the assistance unit shall be determined in accordance with persons considered, as described at subrule 75.56(2).

f. Money which is counted as income for the month and that part of lump-sum income defined at paragraph 75.57(9) “c” reserved for the current or future month’s income.

g. Payments which are exempted for consideration as income and resources under subrule 75.57(6).

h. An equity not to exceed $1,500 in one funeral contract or burial trust for each member of the eligible group. Any amount in excess of $1,500 shall be counted toward resource limits unless it is established that the funeral contract or burial trust is irrevocable.

i. One burial plot for each member of the eligible group. A burial plot is defined as a conventional gravesite, crypt, mausoleum, urn, or other repository which is customarily and traditionally used for the remains of a deceased person.

j. Settlements for payment of medical expenses.

k. Life estates.

l. Federal or state earned income tax credit payments in the month of receipt and the following month, regardless of whether these payments are received with the regular paychecks or as a lump sum with the federal or state income tax refund.

m. The balance in an individual development account (IDA), including interest earned on the IDA.

n. An equity not to exceed $10,000 for tools of the trade or capital assets of self-employed households.

When the value of any resource is exempted in part, that portion of the value which exceeds the exemption shall be considered in calculating whether the eligible group’s property is within the reserve defined in paragraph “e.”

o. Nonhomestead property that produces income consistent with the property’s fair market value.

75.56(2) Persons considered.

a. Resources of persons in the eligible group shall be considered in establishing property limits.

b. Resources of the parent who is living in the home with the eligible children but who is not eligible for Medicaid shall be considered in the same manner as if the parent were eligible for Medicaid.

c. Resources of the stepparent living in the home shall not be considered when determining eligibility of the eligible group, with one exception: The resources of a stepparent included in the eligible group shall be considered in the same manner as a parent.

d. The resources of supplemental security income (SSI) members shall not be counted in establishing property limitations. When property is owned by both the SSI beneficiary and a Medicaid member in another eligible group, each shall be considered as having a half interest in order to determine the value of the resource, unless the terms of the deed or purchase contract clearly establish ownership on a different proportional basis.

e. The resources of a nonparental specified relative who elects to be included in the eligible group shall be considered in the same manner as a parent.

75.56(3) Homestead defined. The homestead consists of the house, used as a home, and may contain one or more contiguous lots or tracts of land, including buildings and appurtenances. When within a city plat, it shall not exceed ½ acre in area. When outside a city plat it shall not contain, in the aggregate, more than 40 acres. When property used as a home exceeds these limitations, the equity value of the excess property shall be determined in accordance with subrule 75.56(5).
75.56(4) **Liquidation.** When proceeds from the sale of resources or conversion of a resource to cash, together with other nonexempted resources, exceed the property limitations, the member is ineligible to receive assistance until the amount in excess of the resource limitation has been expended unless immediately used to purchase a homestead, or reduce the mortgage on a homestead.

a. Property settlements. Property settlements which are part of a legal action in a dissolution of marriage or palimony suit are considered as resources upon receipt.

b. Property sold under installment contract. Property sold under an installment contract or held as security in exchange for a price consistent with its fair market value is exempt as a resource. If the price is not consistent with the contract’s fair market value, the resource value of the installment contract is the gross price for which it can be sold or discounted on the open market, less any legal debts, claims, or liens against the installment contract.

Payments from property sold under an installment contract are exempt as income as specified in paragraphs 75.57(1) “d” and 75.57(7) “ag.” The portion of any payment received representing principal is considered a resource upon receipt. The interest portion of the payment is considered a resource the month following the month of receipt.

75.56(5) **Net market value defined.** Net market value is the gross price for which property or an item can currently be sold on the open market, less any legal debts, claims, or liens against the property or item.

75.56(6) **Availability.**

a. A resource must be available in order for it to be counted toward resource limitations. A resource is considered available under the following circumstances:

1. The applicant or 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 or disposed of at the individual’s discretion.

2. The applicant or member has a legal interest in a liquidated sum and has the legal ability to make the sum available for support and maintenance.


c. When property is owned by more than one person, unless otherwise established, it is assumed that all persons hold equal shares in the property.

d. When the applicant or member owns nonhomestead property, the property shall be considered exempt for so long as the property is publicly advertised for sale at an asking price that is consistent with its fair market value.

75.56(7) **Damage judgments and insurance settlements.**

a. Payment resulting from damage to or destruction of an exempt resource shall be considered a resource to the applicant or member the month following the month the payment was received. When the applicant or member signs a legal binding commitment no later than the month after the month the payment was received, the funds shall be considered exempt for the duration of the commitment providing the terms of the commitment are met within eight months from the date of commitment.

b. Payment resulting from damage to or destruction of a nonexempt resource shall be considered a resource in the month following the month in which payment was received.

75.56(8) **Conservatorships.**

a. Conservatorships established prior to February 9, 1994. The department shall determine whether assets from a conservatorship, except one established solely for the payment of medical expenses, are available by examining the language of the order establishing the conservatorship.

1. Funds clearly conserved and available for care, support, or maintenance shall be considered toward resource or income limitations.

2. When the department worker questions whether the funds in a conservatorship are available, the worker shall refer the conservatorship to the central office. When assets in the conservatorship are not clearly available, central office staff may contact the conservator and request that the funds in the conservatorship be made available for current support and maintenance. When the conservator chooses not to make the funds available, the department may petition the court to have the funds released either partially or in their entirety or as periodic income payments.
(3) Funds in a conservatorship that are not clearly available shall be considered unavailable until the conservator or court actually makes the funds available.

(4) Payments received from the conservatorship for basic or special needs are considered income.

b. Conservatorships established on or after February 9, 1994. Conservatorships established on or after February 9, 1994, shall be treated according to the provisions of paragraphs 75.24(1) "e" and 75.24(2) "b."

75.56(9) Not considered a resource. Inventories and supplies, exclusive of capital assets, that are required for self-employment shall not be considered a resource. Inventory is defined as all unsold items, whether raised or purchased, that are held for sale or use and shall include, but not be limited to, merchandise, grain held in storage and livestock raised for sale. Supplies are items necessary for the operation of the enterprise, such as lumber, paint, and seed. Capital assets are those assets which, if sold at a later date, could be used to claim capital gains or losses for federal income tax purposes. When self-employment is temporarily interrupted due to circumstances beyond the control of the household, such as illness, inventory or supplies retained by the household shall not be considered a resource.

441—75.57(249A) Income. When determining initial and ongoing eligibility for the family medical assistance program (FMAP) and FMAP-related Medicaid coverage groups, all unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted as defined in these rules, shall be considered.

1. Unless otherwise specified at rule 441—75.1(249A), the determination of initial eligibility is a three-step process. Initial eligibility shall be granted only when (1) the countable gross nonexempt unearned and earned income received by the eligible group and available to meet the current month’s needs is no more than 185 percent of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); (2) the countable net earned and unearned income is less than the schedule of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 2); and (3) the countable net unearned and earned income, after applying allowable disregards, is less than the schedule of basic needs as identified at subrule 75.58(2) for the eligible group (Test 3).

2. The determination of continuing eligibility is a two-step process. Continuing eligibility shall be granted only when (1) countable gross nonexempt income, as described for initial eligibility, does not exceed 185 percent of the living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); and (2) countable net unearned and earned income is less than the schedule of basic needs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 3).

3. Child support assigned to the department in accordance with 441—subrule 41.22(7) shall be considered unearned income for the purpose of determining continuing eligibility, except as specified at paragraphs 75.57(1) "e.,” 75.57(6) “u.,” and 75.57(7) “o. " Expenses for care of children or disabled adults, deductions, and diversions shall be allowed when verification is provided.

75.57(1) Unearned income. Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (Federal Insurance Contribution Act, state and federal income taxes). Net unearned income shall be determined by deducting reasonable income-producing costs from the gross unearned income. Money left after this deduction shall be considered gross income available to meet the needs of the eligible group.

a. Social security income is the amount of the entitlement before withholding of a Medicare premium.

b. Financial assistance received for education or training. Rescinded IAB 2/11/98, effective 2/1/98.


d. When the client sells property on contract, proceeds from the sale shall be considered exempt as income. The portion of any payment that represents principal is considered a resource upon receipt as defined in subrule 75.56(4). The interest portion of the payment is considered a resource the month following the month of receipt.
Support payments in cash shall be considered as unearned income in determining initial and continuing eligibility.

1. Any nonexempt cash support payment, for a member of the eligible group, made while the application is pending shall be treated as unearned income.

2. Support payments shall be considered as unearned income in the month in which the IV-A agency (income maintenance) is notified of the payment by the IV-D agency (child support recovery unit).

The amount of income to consider shall be the actual amount paid or the monthly entitlement, whichever is less.

3. Support payments reported by child support recovery during a past month for which eligibility is being determined shall be used to determine eligibility for the month. Support payments anticipated to be received in future months shall be used to determine eligibility for future months. When support payments terminate in the month of decision of an FMAP-related Medicaid application, both support payments already received and support payments anticipated to be received in the month of decision shall be used to determine eligibility for that month.

4. When the reported support payment, combined with other income, creates ineligibility under the current coverage group, an automatic redetermination of eligibility shall be conducted in accordance with the provisions of rule 441—76.11(249A). Persons receiving Medicaid under the family medical assistance program in accordance with subrule 75.1(14) may be entitled to continued coverage under the provisions of subrule 75.1(21). Eligibility may be reestablished for any month in which the countable support payment combined with other income meets the eligibility test.

f. The client shall cooperate in supplying verification of all unearned income and of any change in income, as defined at rule 441—75.50(249A).

1. When the information is available, the department shall verify job insurance benefits by using information supplied to the department by Iowa workforce development. When the department uses this information as verification, job insurance benefits shall be considered received the second day after the date that the check was mailed by Iowa workforce development. When the second day falls on a Sunday or federal legal holiday, the time shall be extended to the next mail delivery day.

2. When the client notifies the department that the amount of job insurance benefits used is incorrect, the client shall be allowed to verify the discrepancy. The client must report the discrepancy before the eligibility month or within ten days of the date on the Notice of Decision, Form 470-0485, 470-0485(S), 470-0486, or 470-0486(S), applicable to the eligibility month, whichever is later.

**75.57(2) Earned income.** Earned income is defined as income in the form of a salary, wages, tips, bonuses, commission earned as an employee, income from Job Corps, or profit from self-employment. Earned income from commissions, wages, tips, bonuses, Job Corps, or salary means the total gross amount irrespective of the expenses of employment. With respect to self-employment, earned income means the net profit from self-employment, defined as gross income less the allowable costs of producing the income. Income shall be considered earned income when it is produced as a result of the performance of services by an individual.

a. Each person in the assistance unit whose gross nonexempt earned income, earned as an employee or net profit from self-employment, considered in determining eligibility is entitled to one 20 percent earned income deduction of nonexempt monthly gross earnings. The deduction is intended to include work-related expenses other than child care. These expenses shall include, but are not limited to, all of the following: taxes, transportation, meals, uniforms, and other work-related expenses.

b. Each person in the assistance unit is entitled to a deduction for care expenses subject to the following limitations.

1. Persons in the eligible group and excluded parents shall be allowed care expenses for a child or incapacitated adult in the eligible group.

2. Stepparents as described at paragraph 75.57(8)“b” and self-supporting parents on underage parent cases as described at paragraph 75.57(8)“c” shall be allowed incapacitated adult care or child care expenses for the ineligible dependents of the stepparent or self-supporting parent.
(3) Unless both parents are in the home and one parent is physically and mentally able to provide the care, child care or care for an incapacitated adult shall be considered a work expense in the amount paid for care of each child or incapacitated adult, not to exceed $175 per month, or $200 per month for a child under the age of two, or the going rate in the community, whichever is less.

(4) If both parents are in the home, adult or child care expenses shall not be allowed when one parent is unemployed and is physically and mentally able to provide the care.

(5) The deduction is allowable only when the care covers the actual hours of the individual’s employment plus a reasonable period of time for commuting; or the period of time when the individual who would normally care for the child or incapacitated adult is employed at such hours that the individual is required to sleep during the waking hours of the child or incapacitated adult, excluding any hours a child is in school.

(6) Any special needs of a physically or mentally handicapped child or adult shall be taken into consideration in determining the deduction allowed.

(7) If the amount claimed is questionable, the expense shall be verified by a receipt or a statement from the provider of care. The expense shall be allowed when paid to any person except a parent or legal guardian of the child, another member of the eligible group, or any person whose needs are met by diversion of income from any person in the eligible group.

   c. Work incentive disregard. After deducting the allowable work-related expenses as defined at paragraphs 75.57(2)“a” and “b” and income diversions as defined at subrule 75.57(4), 58 percent of the total of the remaining monthly nonexempt earned income, earned as an employee or the net profit from self-employment, of each person whose income must be considered is disregarded in determining eligibility for the family medical assistance program (FMAP) and those FMAP-related coverage groups subject to the three-step process for determining initial eligibility as described at rule 441—75.57(249A).

   (1) The work incentive disregard is not time-limited.

   (2) Initial eligibility under the first two steps of the three-step process is determined without the application of the work incentive disregard as described at subparagraphs 75.57(9)“a”(2) and (3).

   (3) A person who is not eligible for Medicaid because the person has refused to cooperate in applying for or accepting benefits from other sources, in accordance with the provisions of rule 441—75.2(249A), 441—75.3(249A), or 441—75.21(249A), is eligible for the work incentive disregard.


   e. A person is considered self-employed when the person:

      (1) Is not required to report to the office regularly except for specific purposes such as sales training meetings, administrative meetings, or evaluation sessions.

      (2) Establishes the person’s own working hours, territory, and methods of work.

      (3) Files quarterly reports of earnings, withholding payments, and FICA payments to the Internal Revenue Service.

   f. The net profit from self-employment income in a non-home-based operation shall be determined by deducting only the following expenses that are directly related to the production of the income:

      (1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.

      (2) Wages, commissions, and mandated costs relating to the wages for employees of the self-employed.

      (3) The cost of shelter in the form of rent, the interest on mortgage or contract payments; taxes; and utilities.

      (4) The cost of machinery and equipment in the form of rent or the interest on mortgage or contract payments.

      (5) Insurance on the real or personal property involved.

      (6) The cost of any repairs needed.

      (7) The cost of any travel required.

      (8) Any other expense directly related to the production of income, except the purchase of capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.
g. When the client is renting out apartments in the client’s home, the following shall be deducted from the gross rentals received to determine the profit:
   (1) Shelter expense in excess of that set forth on the chart of basic needs components at subrule 75.58(2) for the eligible group.
   (2) That portion of expense for utilities furnished to tenants which exceeds the amount set forth on the chart of basic needs components at subrule 75.58(2).
   (3) Ten percent of gross rentals to cover the cost of upkeep.

h. In determining profit from furnishing board, room, operating a family-life home, or providing nursing care, the following amounts shall be deducted from the payments received:
   (1) $41 plus an amount equivalent to the monthly maximum food assistance program benefit for a one-member household for a boarder and roomer or an individual in the home to receive nursing care, or $41 for a roomer, or an amount equivalent to the monthly maximum food assistance program benefit for a one-member household for a boarder.
   (2) Ten percent of the total payment to cover the cost of upkeep for individuals receiving a room or nursing care.
   i. Gross income from providing child care in the applicant’s or member’s own home shall include the total payments received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children.
   (1) In determining profit from providing child care services in the applicant’s or member’s own home, 40 percent of the total gross income received shall be deducted to cover the costs of producing the income, unless the applicant or member requests to have actual expenses in excess of the 40 percent considered.
   (2) When the applicant or member requests to have expenses in excess of the 40 percent considered, profit shall be determined in the same manner as specified at paragraph 75.57(2) "j."
   j. In determining profit for a self-employed enterprise in the home other than providing room and board, renting apartments or providing child care services, the following expenses shall be deducted from the income received:
   (1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.
   (2) Wages, commissions, and mandated costs relating to the wages for employees.
   (3) The cost of machinery and equipment in the form of rent; or the interest on mortgage or contract payment; and any insurance on such machinery equipment.
   (4) Ten percent of the total gross income to cover the costs of upkeep when the work is performed in the home.
   (5) Any other direct cost involved in the production of the income, except the purchase of capital equipment and payment on the principal of loans for capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.
   l. The applicant or member shall cooperate in supplying verification of all earned income and of any change in income, as defined at rule 441—75.50(249A). A self-employed applicant or member shall keep any records necessary to establish eligibility.

75.57(3) Shared living arrangements. When an applicant or member shares living arrangements with another family or person, funds combined to meet mutual obligations for shelter and other basic needs are not income. Funds made available to the applicant or member, exclusively for the applicant’s or member’s needs, are considered income.

75.57(4) Diversion of income.
   a. Nonexempt earned and unearned income of the parent shall be diverted to meet the unmet needs of the ineligible children of the parent living in the family group who meet the age and school attendance requirements specified in subrule 75.54(1). Income of the parent shall be diverted to meet the unmet needs of the ineligible children of the parent and a companion in the home only when the income and resources of the companion and the children are within family medical assistance program standards. The maximum income that shall be diverted to meet the needs of the ineligible children shall be the
difference between the needs of the eligible group if the ineligible children were included and the needs of the eligible group with the ineligible children excluded, except as specified at paragraph 75.57(8) "b." 

b. Nonexempt earned and unearned income of the parent shall be diverted to permit payment of court-ordered support to children not living with the parent when the payment is actually being made.

75.57(5) Income of unmarried specified relatives under the age of 19.

a. Income of the unmarried specified relative under the age of 19 when that specified relative lives with a parent who receives coverage under family medical assistance-related programs or lives with a nonparental relative or in an independent living arrangement.

(1) The income of the unmarried, under age specified relative who is also an eligible child in the eligible group of the specified relative’s parent shall be treated in the same manner as that of any other child. The income for the unmarried, under age specified relative who is not an eligible child in the eligible group of the specified relative’s parent shall be treated in the same manner as though the specified relative had attained majority.

(2) The income of the unmarried, under age specified relative living with a nonparental relative or in an independent living arrangement shall be treated in the same manner as though the specified relative had attained majority.

b. Income of the unmarried specified relative under the age of 19 who lives in the same home as a self-supporting parent. The income of the unmarried specified relative under the age of 19 living in the same home as a self-supporting parent shall be treated in accordance with subparagraphs (1), (2), and (3) below.

(1) When the unmarried specified relative is under the age of 18 and not a parent of the dependent child, the income of the specified relative shall be exempt.

(2) When the unmarried specified relative is under the age of 18 and a parent of the dependent child, the income of the specified relative shall be treated in the same manner as though the specified relative had attained majority. The income of the specified relative’s self-supporting parents shall be treated in accordance with paragraph 75.57(8) "c."

(3) When the unmarried specified relative is 18 years of age, the specified relative’s income shall be treated in the same manner as though the specified relative had attained majority.

75.57(6) Exempt as income and resources. The following shall be exempt as income and resources:

a. Food reserves from home-produced garden products, orchards, domestic animals, and the like, when used by the household for its own consumption.

b. The value of the food assistance program benefit.

c. The value of the United States Department of Agriculture donated foods (surplus commodities).

d. The value of supplemental food assistance received under the Child Nutrition Act and the special food service program for children under the National School Lunch Act.

e. Any benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act.


g. Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968.

h. Any judgment funds that have been or will be distributed per capita or held in trust for members of any Indian tribe. When the payment, in all or part, is converted to another type of resource, that resource is also exempt.

i. Payments to volunteers participating in the Volunteers in Service to America (VISTA) program, except that this exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteers are serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938, or the minimum wage under the laws of the state where the volunteers are serving, whichever is greater.

j. Payments for supporting services or reimbursement of out-of-pocket expenses received by volunteers in any of the programs established under Titles II and III of the Domestic Volunteer Services Act.
k. Tax-exempt portions of payments made pursuant to the Alaskan Native Claims Settlement Act.
l. Experimental housing allowance program payments made under annual contribution contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1936 as amended.
m. The income of a supplemental security income recipient.
n. Income of an ineligible child.
o. Income in-kind.
p. Family support subsidy program payments.
q. Grants obtained and used under conditions that preclude their use for current living costs.
r. All earned and unearned educational funds of an undergraduate or graduate student or a person in training. Any extended social security or veterans benefits received by a parent or nonparental relative as defined at subrule 75.55(1), conditional to school attendance, shall be exempt. However, any additional amount received for the person’s dependents who are in the eligible group shall be counted as nonexempt income.
s. Subsidized guardianship program payments.
t. Any income restricted by law or regulation which is paid to a representative payee living outside the home, unless the income is actually made available to the applicant or member by the representative payee.
u. The first $50 received by the eligible group which represents a current monthly support obligation or a voluntary support payment, paid by a legally responsible individual, but in no case shall the total amount exempted exceed $50 per month per eligible group.
v. Bona fide loans. Evidence of a bona fide loan may include any of the following:
   (1) The loan is obtained from an institution or person engaged in the business of making loans.
   (2) There is a written agreement to repay the money within a specified time.
   (3) If the loan is obtained from a person not normally engaged in the business of making a loan, there is borrower’s acknowledgment of obligation to repay (with or without interest), or the borrower expresses intent to repay the loan when funds become available in the future, or there is a timetable and plan for repayment.
w. Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.).
x. The income of a person ineligible due to receipt of state-funded foster care, IV-E foster care, or subsidized adoption assistance.
y. Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.
z. Payments made to certain United States citizens of Japanese ancestry and resident Japanese aliens under Section 105 of Public Law 100-383, and payments made to certain eligible Aleuts under Section 206 of Public Law 100-383, entitled “Wartime Relocation of Civilians.”
   aa. Payments received from the Radiation Exposure Compensation Act.
   ab. Deposits into an individual development account (IDA) when determining eligibility. The amount of the deposit is exempt as income and shall not be used in the 185 percent eligibility test. Deposits shall be deducted from nonexempt earned and unearned income beginning with the month following the month in which verification that deposits have begun is received. The client shall be allowed a deduction only when the deposit is made from the client’s money. The earned income deductions at paragraphs 75.57(2)"a," "b," and "c" shall be applied to nonexempt earnings from employment or net profit from self-employment that remains after deducting the amount deposited into the account. Allowable deductions shall be applied to any nonexempt unearned income that remains after deducting the amount of the deposit. If the client has both nonexempt earned and unearned income, the amount deposited into the IDA account shall first be deducted from the client’s nonexempt unearned income. Deposits shall not be deducted from earned or unearned income that is exempt.

75.57(7) Exempt as income. The following are exempt as income.
   a. Reimbursements from a third party.
   b. Reimbursement from the employer for a job-related expense.
c. The following nonrecurring lump sum payments:
   (1) Income tax refund.
   (2) Retroactive supplemental security income benefits.
   (3) Settlements for the payment of medical expenses.
   (4) Refunds of security deposits on rental property or utilities.
   (5) That part of a lump sum received and expended for funeral and burial expenses.
   (6) That part of a lump sum both received and expended for the repair or replacement of resources.
   d. Payments received by the family for providing foster care when the family is operating a licensed foster home.
   e. A small monetary nonrecurring gift, such as a Christmas, birthday or graduation gift, not to exceed $30 per person per calendar quarter.

   When a monetary gift from any one source is in excess of $30, the total gift is countable as unearned income. When monetary gifts from several sources are each $30 or less, and the total of all gifts exceeds $30, only the amount in excess of $30 is countable as unearned income.
   f. Federal or state earned income tax credit.
   g. Supplementation from county funds, providing:
      (1) The assistance does not duplicate any of the basic needs as recognized by the chart of basic needs components in accordance with subrule 75.58(2), or
      (2) The assistance, if a duplication of any of the basic needs, is made on an emergency basis, not as ongoing supplementation.
   h. Any payment received as a result of an urban renewal or low-cost housing project from any governmental agency.
   i. A retroactive corrective family investment program (FIP) payment.
   j. The training allowance issued by the division of vocational rehabilitation, department of education.
   k. Payments from the PROMISE JOBS program.
   l. The training allowance issued by the department for the blind.
   m. Payments from passengers in a car pool.
   n. Support refunded by the child support recovery unit for the first month of termination of eligibility and the family does not receive the family investment program.
   o. Rescinded IAB 10/4/00, effective 10/1/00.
   p. Rescinded IAB 10/4/00, effective 10/1/00.
   q. Income of a nonparental relative as defined at subrule 75.55(1) except when the relative is included in the eligible group.
   r. Rescinded IAB 10/4/00, effective 10/1/00.
   s. Compensation in lieu of wages received by a child funded through an employment and training program of the U.S. Department of Labor.
   t. Any amount for training expenses included in a payment funded through an employment and training program of the U.S. Department of Labor.
   u. Earnings of a person aged 19 or younger who is a full-time student as defined at subparagraphs 75.54(1) “b”(1) and (2). The exemption applies through the entire month of the person’s twentieth birthday.

   EXCEPTION: When the twentieth birthday falls on the first day of the month, the exemption stops on the first day of that month.
   v. Income attributed to an unmarried, underage parent in accordance with paragraph 75.57(8) “c” effective the first day of the month following the month in which the unmarried, underage parent turns age 18 or reaches majority through marriage. When the unmarried, underage parent turns 18 on the first day of a month, the income of the self-supporting parents becomes exempt as of the first day of that month.
   w. Incentive payments received from participation in the adolescent pregnancy prevention programs.
x. Payments received from the comprehensive child development program, funded by the Administration for Children, Youth, and Families, provided the payments are considered complimentary assistance by federal regulation.

y. Incentive allowance payments received from the work force investment project, provided the payments are considered complimentary assistance by federal regulation.

z. Interest and dividend income.

aa. Rescinded IAB 10/4/00, effective 10/1/00.

ab. Honorarium income. All moneys paid to an eligible household in connection with the welfare reform demonstration longitudinal study or focus groups shall be exempted.

ac. Income that an individual contributes to a trust as specified at paragraph 75.24(3)“b” shall not be considered for purposes of determining eligibility for the family medical assistance program (FMAP) or FMAP-related Medicaid coverage groups.

ad. Benefits paid to the eligible household under the family investment program (FIP).

ae. Moneys received through the pilot self-sufficiency grants program or through the pilot diversion program.

af. Earnings from new employment of any person whose income is considered when determining eligibility during the first four calendar months of the new employment. The date the new employment or self-employment begins shall be verified before approval of the exemption. This four-month period shall be referred to as the work transition period (WTP).

1. The exempt period starts the first day of the month in which the client receives the first pay from the new employment and continues through the next three benefit months, regardless if the job ends during the four-month period.

2. To qualify for this disregard, the person shall not have earned more than $1,200 in the 12 calendar months prior to the month in which the new job begins, the income must be reported timely in accordance with rule 441—76.10(249A), and the new job must have started after the date the application is filed. For purposes of this policy, the $1,200 earnings limit applies to the gross amount of income without any allowance for exemptions, disregards, work deductions, diversions, or the costs of doing business used in determining net profit from any income test in rule 441—75.57(249A).

3. If another new job or self-employment enterprise starts while a WTP is in progress, the exemption shall also be applied to earnings from the new source that are received during the original 4-month period, provided that the earnings were less than $1,200 in the 12-month period before the month the other new job or self-employment enterprise begins.

4. An individual is allowed the 4-month exemption period only once in a 12-month period. An additional 4-month exemption shall not be granted until the month after the previous 12-month period has expired.

5. If a person whose income is considered enters the household, the new job must start after the date the person enters the home or after the person is reported in the home, whichever is later, in order for that person to qualify for the exemption.

6. When a person living in the home whose income is not considered subsequently becomes an assistance unit member whose income is considered, the new job must start after the date of the change that causes the person’s income to be considered in order for that person to qualify for the exemption.

7. A person who begins new employment or self-employment that is intermittent in nature may qualify for the WTP. “Intermittent” includes, but is not limited to, working for a temporary agency that places the person in different job assignments on an as-needed or on-call basis, or self-employment from providing child care for one or more families. However, a person is not considered as starting new employment or self-employment each time intermittent employment restarts or changes such as when the same temporary agency places the person in a new assignment or a child care provider acquires another child care client.

ag. Payments from property sold under an installment contract as specified in paragraphs 75.56(4)“b” and 75.57(1)“d.”

ah. All census earnings received by temporary workers from the Bureau of the Census.
ai. Payments received through participation in the preparation for adult living program pursuant to 441—Chapter 187.

75.57(8) Treatment of income in excluded parent cases, stepparent cases, and underage parent cases.

a. Treatment of income in excluded parent cases. A parent who is living in the home with the eligible children but who is not eligible for Medicaid is eligible for the 20 percent earned income deduction, child care expenses for children in the eligible group, the 58 percent work incentive disregard described at paragraphs 75.57(2) “a,” “b,” and “c,” and diversions described at subrule 75.57(4). All remaining nonexempt income of the parent shall be applied against the needs of the eligible group.

b. Treatment of income in stepparent cases. The income of a stepparent who is not included in the eligible group but who is living with the parent in the home of an eligible child shall be given the same consideration and treatment as that of a parent subject to the limitations of subparagraphs (1) through (10) below.

1. The stepparent’s monthly gross nonexempt earned income, earned as an employee or monthly net profit from self-employment, shall receive a 20 percent earned income deduction.

2. The stepparent’s monthly nonexempt earned income remaining after the 20 percent earned income deduction shall be allowed child care expenses for the stepparent’s ineligible dependents in the home, subject to the restrictions described at subparagraphs 75.57(2) “b”(1) through (5).

3. Any amounts actually paid by the stepparent to individuals not living in the home, who are claimed or could be claimed by the stepparent as dependents for federal income tax purposes, shall be deducted from nonexempt monthly earned and unearned income of the stepparent.

4. The stepparent shall also be allowed a deduction from nonexempt monthly earned and unearned income for alimony and child support payments made to individuals not living in the home with the stepparent.

5. Except as described at subrule 75.57(10), the nonexempt monthly earned and unearned income of the stepparent remaining after application of the deductions at subparagraphs 75.57(8) “b”(1) through (4) above shall be used to meet the needs of the stepparent and the stepparent’s dependents living in the home, when the dependents’ needs are not included in the eligible group and the stepparent claims or could claim the dependents for federal income tax purposes. These needs shall be determined in accordance with the schedule of needs for a family group of the same composition in accordance with subrule 75.58(2).

6. The stepparent shall be allowed the 58 percent work incentive disregard from monthly earnings. The disregard shall be applied to earnings that remain after all other deductions at subparagraphs 75.57(8) “b”(1) through (5) have been subtracted from the earnings. However, the work incentive disregard is not allowed when determining initial eligibility as described at subparagraphs 75.57(9) “a”(2) and (3).

7. The deductions described in subparagraphs (1) through (6) shall first be subtracted from earned income in the same order as they appear above.

When the stepparent has both nonexempt earned and unearned income and earnings are less than the allowable deductions, then any remaining portion of the deductions in subparagraphs (3) through (5) shall be subtracted from unearned income. Any remaining income shall be applied as unearned income to the needs of the eligible group.

If the stepparent has earned income remaining after allowable deductions, then any nonexempt unearned income shall be added to the earnings and the resulting total counted as unearned income to the needs of the eligible group.

8. A nonexempt, nonrecurring lump sum received by a stepparent shall be considered as income and counted in computing eligibility in the same manner as it would be treated for a parent. Any portion of the nonrecurring lump sum retained by the stepparent in the month following the month of receipt shall be considered a resource to the stepparent if that portion is not exempted according to paragraph 75.56(1) “f.”

9. When the income of the stepparent, not in the eligible group, is insufficient to meet the needs of the stepparent and the stepparent’s dependents living in the home who are not eligible for FMAP-related
Medicaid, the income of the parent may be diverted to meet the unmet needs of the children of the current marriage except as described at subrule 75.57(10).

(10) When the needs of the stepparent, living in the home, are not included in the eligible group, the eligible group and any children of the parent living in the home who are not eligible for FMAP-related Medicaid shall be considered as one unit, and the stepparent and the stepparent’s dependents, other than the spouse, shall be considered a separate unit.


c. Treatment of income in under age parent cases. In the case of a dependent child whose unmarried parent is under the age of 18 and living in the same home as the unmarried, underage parent’s own self-supporting parents, the income of each self-supporting parent shall be considered available to the eligible group after appropriate deductions unless the provisions of rule 441—75.59(249A) apply. The deductions to be applied are the same as are applied to the income of a stepparent pursuant to subparagraphs 75.57(8) “b”(1) through (7). Child care expenses at subparagraph 75.57(8) “b”(2) shall be allowed for the self-supporting parent’s ineligible children. Nonrecurring lump sum income received by the self-supporting parent(s) shall be treated in accordance with subparagraph 75.57(8) “b”(8).

When the self-supporting spouse of a self-supporting parent is also living in the home, the income of that spouse shall be attributable to the self-supporting parent in the same manner as the income of a stepparent is determined pursuant to subparagraphs 75.57(8) “b”(1) through (7) unless the provisions of rule 441—75.59(249A) apply. Child care expenses at subparagraph 75.57(8) “b”(2) shall be allowed for the ineligible dependents of the self-supporting spouse who is a stepparent of the minor parent. Nonrecurring lump sum income received by the spouse of the self-supporting parent shall be treated in accordance with subparagraph 75.57(8) “b”(8). The self-supporting spouse and any ineligible dependents of that person shall be considered as one unit. The self-supporting spouse and the spouse’s ineligible dependents, other than the self-supporting parent, shall be considered a separate unit.

75.57(9) Budgeting process.

a. Initial and ongoing eligibility. Both initial and ongoing eligibility shall be based on a projection of income based on the best estimate of future income.

(1) Upon application, the department shall use all earned and unearned income received by the eligible group to project future income. Allowable work expenses shall be deducted from earned income, except in determining eligibility under the 185 percent test defined at rule 441—75.57(249A). The determination of initial eligibility is a three-step process as described at rule 441—75.57(249A).

(2) Test 1. When countable gross nonexempt earned and unearned income exceeds 185 percent of the schedule of living costs (Test 1), as identified at subrule 75.58(2) for the eligible group, eligibility does not exist under any coverage group for which these income tests apply. Countable gross income means nonexempt gross income, as defined at rule 441—75.57(249A), without application of any disregards, deductions, or diversions.

(3) Test 2. When the countable gross nonexempt earned and unearned income equals or is less than 185 percent of the schedule of living costs for the eligible group, initial eligibility under the schedule of living costs (Test 2) shall then be determined. Initial eligibility under the schedule of living costs is determined without application of the 58 percent work incentive disregard as specified at paragraph 75.57(2)”c.” All other appropriate exemptions, deductions and diversions are applied. Countable income is then compared to the schedule of living costs (Test 2) for the eligible group. When countable net earned and unearned income equals or exceeds the schedule of living costs for the eligible group, eligibility does not exist under any coverage group for which these income tests apply.

(4) Test 3. After application of Tests 1 and 2 for initial eligibility or of Test 1 for ongoing eligibility, the 58 percent work incentive disregard at paragraph 75.57(2)”c” shall be applied when there is eligibility for this disregard. When countable net earned and unearned income, after application of the work incentive disregard and all other appropriate exemptions, deductions, and diversions, equals or exceeds the schedule of basic needs (Test 3) for the eligible group, eligibility does not exist under any coverage group for which these tests apply. When the countable net income is less than the schedule of basic needs for the eligible group, the eligible group meets FMAP or CMAP income requirements.

(5) Rescinded IAB 10/4/00, effective 10/1/00.
(6) When income received weekly or biweekly (once every two weeks) is projected for future months, it shall be projected by adding all income received in the time period being used and dividing the result by the number of instances of income received in that time period. The result shall be multiplied by four if the income is received weekly, or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

(7) Rescinded IAB 7/4/07, effective 8/1/07.

(8) When a change in circumstances that is required to be timely reported by the client pursuant to paragraphs 75.52(4) “d” and “e” is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change occurred. When a change in circumstances that is required to be reported by the client at annual review or upon the addition of an individual to the eligible group pursuant to paragraph 75.52(4) “c” is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change was required to be reported. All other changes shall be acted upon when they are reported or otherwise become known to the department, allowing for a ten-day notice of adverse action, if required.

b. Recurring lump-sum income. Recurring lump-sum earned and unearned income, except for the income of the self-employed, shall be prorated over the number of months for which the income was received and applied to the eligibility determination for the same number of months.

(1) Income received by an individual employed under a contract shall be prorated over the period of the contract.

(2) Income received at periodic intervals or intermittently shall be prorated over the period covered by the income and applied to the eligibility determination for the same number of months. EXCEPTION: Periodic or intermittent income from self-employment shall be treated as described at paragraph 75.57(9)”i.”

(3) When the lump-sum income is earned income, appropriate disregards, deductions and diversions shall be applied to the monthly prorated income. Income is prorated when a recurring lump sum is received at any time.

c. Nonrecurring lump-sum income. Moneys received as a nonrecurring lump sum, except as specified in subrules 75.56(4) and 75.56(7) and at paragraphs 75.57(8) “b” and “c,” shall be treated in accordance with this rule. Nonrecurring lump-sum income includes an inheritance, an insurance settlement or tort recovery, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits, such as social security, job insurance, or workers’ compensation.

(1) Nonrecurring lump-sum income shall be considered as income in the month of receipt and counted in computing eligibility, unless the income is exempt.

(2) When countable income exclusive of any family investment program grant but including countable lump-sum income exceeds the needs of the eligible group under their current coverage group, the countable lump-sum income shall be prorated. The number of full months for which a monthly amount of the lump sum shall be counted as income in the eligibility determination is derived by dividing the total of the lump-sum income and any other countable income received in or projected to be received in the month the lump sum was received by the schedule of living costs, as identified at subrule 75.58(2), for the eligible group. This period is referred to as the period of proration. Any income remaining after this calculation shall be applied as income to the first month following the period of proration and disregarded as income thereafter.

(3) The period of proration shall begin with the month when the nonrecurring lump sum was received, whether or not the receipt of the lump sum was timely reported. If receipt of the lump sum was reported timely and the calculation was completed timely, no recoupment shall be made. If receipt of the lump sum was not reported timely or the calculation was not completed timely, recoupment shall begin with the month of receipt of the nonrecurring lump sum.

(4) The period of proration shall be shortened when:
1. The schedule of living costs as defined at subrule 75.58(2) increases; or
2. A portion of the lump sum is no longer available to the eligible group due to loss or theft or because the person controlling the lump sum no longer resides with the eligible group and the lump sum is no longer available to the eligible group; or
3. There is an expenditure of the lump sum made for the following circumstances unless there was insurance available to meet the expense: Payments made on medical services for the former eligible group or their dependents for services listed in 441—Chapters 78, 81, 82, and 85 at the time the expense is reported to the department; the cost of necessary repairs to maintain habitability of the homestead requiring the spending of over $25 per incident; cost of replacement of exempt resources as defined in subrule 75.56(1) due to fire, tornado, or other natural disaster; or funeral and burial expenses. The expenditure of these funds shall be verified.

(5) When countable income, including the lump-sum income, is less than the needs of the eligible group in accordance with the provisions of their current coverage group, the lump sum shall be counted as income for the month of receipt.

(6) For purposes of applying the lump-sum provision, the eligible group is defined as all eligible persons and any other individual whose lump-sum income is counted in determining the period of proration.

(7) During the period of proration, individuals not in the eligible group when the lump-sum income was received may be eligible as a separate eligible group. Income of this eligible group plus income of the parent or other legally responsible person in the home, excluding the lump-sum income already considered, shall be considered as available in determining eligibility.

d. The third digit to the right of the decimal point in any calculation of income, hours of employment and work expenses for care, as defined at paragraph 75.57(2) “b.” shall be dropped.

e. In any month for which an individual is determined eligible to be added to a currently active family medical assistance (FMAP) or FMAP-related Medicaid case, the individual’s needs, income, and resources shall be included. An individual who is a member of the eligible group and who is determined to be ineligible for Medicaid shall be canceled prospectively effective the first of the following month if the timely notice of adverse action requirements as provided at 441—subrule 76.4(1) can be met.

f. Rescinded IAB 10/4/00, effective 10/1/00.

g. Rescinded IAB 2/1/98, effective 2/1/98.

h. Income from self-employment received on a regular weekly, biweekly, semimonthly or monthly basis shall be budgeted in the same manner as the earnings of an employee. The countable income shall be the net income.

i. Income from self-employment not received on a regular weekly, biweekly, semimonthly or monthly basis that represents an individual’s annual income shall be averaged over a 12-month period of time, even if the income is received within a short period of time during that 12-month period. Any change in self-employment shall be handled in accordance with subparagraphs (3) through (5) below.

(1) When a self-employment enterprise which does not produce a regular weekly, biweekly, semimonthly or monthly income has been in existence for less than a year, income shall be averaged over the period of time the enterprise has been in existence and the monthly amount projected for the same period of time. If the enterprise has been in existence for such a short time that there is very little income information, the worker shall establish, with the cooperation of the client, a reasonable estimate which shall be considered accurate and projected for three months, after which the income shall be averaged and projected for the same period of time. Any changes in self-employment shall be considered in accordance with subparagraphs (3) through (5) below.

(2) These policies apply when the self-employment income is received before the month of decision and the income is expected to continue, in the month of decision, after assistance is approved.

(3) A change in the cost of producing self-employment income is defined as an established permanent ongoing change in the operating expenses of a self-employment enterprise. Change in self-employment income is defined as a change in the nature of business.

(4) When a change in operating expenses occurs, the department shall recalculate the expenses on the basis of the change.

(5) When a change occurs in the nature of the business, the income and expenses shall be computed on the basis of the change.

\textbf{75.57(10) Restriction on diversion of income.} Rescinded IAB 7/11/01, effective 9/1/01.
75.57(11) Divesting of income. Assistance shall not be approved when an investigation proves that income was divested and the action was deliberate and for the primary purpose of qualifying for assistance or increasing the amount of assistance paid.

[ARC 8500B, IAB 2/10/10, effective 3/1/10; ARC 8556B, IAB 3/10/10, effective 2/10/10; ARC 9043B, IAB 9/8/10, effective 11/1/10]

441—75.58(249A) Need standards.

75.58(1) Definition of eligible group. The eligible group consists of all eligible persons specified below and living together, except when one or more of these persons have elected to receive supplemental security income under Title XVI of the Social Security Act or are voluntarily excluded in accordance with the provisions of rule 441—75.59(249A). There shall be at least one child, which may be an unborn child, in the eligible group except when the only eligible child is receiving supplemental security income.

a. The following persons shall be included (except as otherwise provided in these rules) without regard to the person’s employment status, income or resources:

1. All dependent children who are siblings of whole or half blood or adoptive.
2. Any parent of such children, if the parent is living in the same home as the dependent children.

b. The following persons may be included:

1. The needy specified relative who assumes the role of parent.
2. The needy specified relative who acts as caretaker when the parent is in the home but is unable to act as caretaker.

(3) An incapacitated stepparent, upon request, when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the stepparent does not have a child in the eligible group.

1. A stepparent is considered incapacitated when a clearly identifiable physical or mental defect has a demonstrable effect upon earning capacity or the performance of the homemaking duties required to maintain a home for the stepchild. The incapacity shall be expected to last for a period of at least 30 days from the date of application.

2. The determination of incapacity shall be supported by medical or psychological evidence. The evidence may be submitted either by letter from the physician or on Form 470-0447, Report on Incapacity.

3. When an examination is required and other resources are not available to meet the expense of the examination, the physician shall be authorized to make the examination and submit the claim for payment on Form 470-0502, Authorization for Examination and Claim for Payment.

4. A finding of eligibility for social security benefits or supplemental security income benefits based on disability or blindness is acceptable proof of incapacity for the family medical assistance program (FMAP) and FMAP-related program purposes.

5. A stepparent who is considered incapacitated and is receiving Medicaid shall be referred to the department of education, division of vocational rehabilitation services, for evaluation and services. Acceptance of these services is optional.

(4) The stepparent who is not incapacitated when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the stepparent is required in the home to care for the dependent children. These services must be required to the extent that if the stepparent were not available, it would be necessary to allow for care as a deduction from earned income of the parent.

75.58(2) Schedule of needs. The schedule of living costs represents 100 percent of the basic needs. The schedule of living costs is used to determine the needs of individuals when these needs must be determined in accordance with the schedule of needs defined at rule 441—75.50(249A). The 185 percent schedule is included for the determination of eligibility in accordance with rule 441—75.57(249A). The schedule of basic needs is used to determine the basic needs of those persons whose needs are included in the eligible group. The eligible group is considered a separate and distinct group without regard to the presence in the home of other persons, regardless of relationship to or whether they have a liability to support members of the eligible group. The schedule of basic needs is also used to determine the needs of persons not included in the eligible group. The percentage of basic needs paid to one or more persons as compared to the schedule of living costs is shown on the chart below:
## SCHEDULE OF NEEDS

<table>
<thead>
<tr>
<th>Number of Persons</th>
<th>Each Additional Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test 1 185% of Living Costs</td>
<td>675.25 1330.15 1570.65 1824.10 2020.20 2249.60 2469.75 2695.45 2915.60 3189.40 320.05</td>
</tr>
<tr>
<td>Test 2 Schedule of Living Costs</td>
<td>365 719 849 986 1092 1216 1335 1457 1576 1724 173</td>
</tr>
<tr>
<td>Test 3 Schedule of Basic Needs</td>
<td>183 361 426 495 548 610 670 731 791 865 87</td>
</tr>
<tr>
<td>Ratio of Basic Needs to Living Costs</td>
<td>50.18 50.18 50.18 50.18 50.18 50.18 50.18 50.18 50.18 50.18</td>
</tr>
</tbody>
</table>

## CHART OF BASIC NEEDS COMPONENTS

(all figures are on a per person basis)

<table>
<thead>
<tr>
<th>Number of Persons</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10 or More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shelter</td>
<td>77.14</td>
<td>65.81</td>
<td>47.10</td>
<td>35.20</td>
<td>31.74</td>
<td>26.28</td>
<td>25.69</td>
<td>22.52</td>
<td>20.91</td>
<td>20.58</td>
</tr>
<tr>
<td>Utilities</td>
<td>19.29</td>
<td>16.45</td>
<td>11.77</td>
<td>8.80</td>
<td>7.93</td>
<td>6.57</td>
<td>6.42</td>
<td>5.63</td>
<td>5.23</td>
<td>5.14</td>
</tr>
<tr>
<td>Household Supplies</td>
<td>4.27</td>
<td>5.33</td>
<td>4.01</td>
<td>3.75</td>
<td>3.36</td>
<td>3.26</td>
<td>3.10</td>
<td>3.08</td>
<td>2.97</td>
<td>2.92</td>
</tr>
<tr>
<td>Food</td>
<td>34.49</td>
<td>44.98</td>
<td>40.31</td>
<td>39.11</td>
<td>36.65</td>
<td>37.04</td>
<td>34.00</td>
<td>33.53</td>
<td>32.87</td>
<td>32.36</td>
</tr>
<tr>
<td>Clothing</td>
<td>11.17</td>
<td>11.49</td>
<td>8.70</td>
<td>8.75</td>
<td>6.82</td>
<td>6.84</td>
<td>6.54</td>
<td>6.39</td>
<td>6.20</td>
<td>6.10</td>
</tr>
<tr>
<td>Pers. Care &amp; Supplies</td>
<td>3.29</td>
<td>3.64</td>
<td>2.68</td>
<td>2.38</td>
<td>2.02</td>
<td>1.91</td>
<td>1.82</td>
<td>1.72</td>
<td>1.67</td>
<td>1.64</td>
</tr>
<tr>
<td>Med. Chest Supplies</td>
<td>.99</td>
<td>1.40</td>
<td>1.34</td>
<td>1.13</td>
<td>1.15</td>
<td>1.11</td>
<td>1.08</td>
<td>1.06</td>
<td>1.09</td>
<td>1.08</td>
</tr>
<tr>
<td>Communications</td>
<td>7.23</td>
<td>6.17</td>
<td>3.85</td>
<td>3.25</td>
<td>2.50</td>
<td>2.07</td>
<td>1.82</td>
<td>1.66</td>
<td>1.51</td>
<td>1.49</td>
</tr>
<tr>
<td>Transportation</td>
<td>25.13</td>
<td>25.23</td>
<td>22.24</td>
<td>21.38</td>
<td>17.43</td>
<td>16.59</td>
<td>15.24</td>
<td>15.79</td>
<td>15.44</td>
<td>15.19</td>
</tr>
</tbody>
</table>

### a. The definitions of the basic need components are as follows:

1. Shelter: Rental, taxes, upkeep, insurance, amortization.
2. Utilities: Fuel, water, lights, water heating, refrigeration, garbage.
6. Personal care and supplies: Including regular school supplies.
7. Medicine chest items.
8. Communications: Telephone, newspapers, magazines.

### b. Special situations in determining eligible group:

1. The needs of a child or children in a nonparental home shall be considered a separate eligible group when the relative is receiving Medicaid for the relative’s own children.
(2) When the unmarried specified relative under the age of 19 is living in the same home with a parent or parents who receive Medicaid, the needs of the specified relative, when eligible, shall be included in the same eligible group with the parents. When the specified relative is a parent, the needs of the eligible children for whom the unmarried parent is caretaker shall be included in the same eligible group. When the specified relative is a nonparental relative, the needs of the eligible children for whom the specified relative is caretaker shall be considered a separate eligible group.

When the unmarried specified relative under the age of 19 is living in the same home as a parent who receives Medicaid but the specified relative is not an eligible child, need of the specified relative shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative under the age of 19 is living with a nonparental relative or in an independent living arrangement, need shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative is under the age of 18 and living in the same home with a parent who does not receive Medicaid, the needs of the specified relative, when eligible, shall be included in the eligible group with the children when the specified relative is a parent. When the specified relative is a nonparental relative as defined at subrule 75.55(1), only the needs of the eligible children shall be included in the eligible group. When the unmarried specified relative is aged 18, need shall be determined in the same manner as though the specified relative had attained majority.

(3) When a person who would ordinarily be in the eligible group has elected to receive supplemental security income benefits, the person, income and resources shall not be considered in determining eligibility for the rest of the family.

(4) When two individuals, married to each other, are living in a common household and the children of each of them are recipients of Medicaid, the eligibility shall be computed on the basis of their comprising one eligible group.

(5) When a child is ineligible for Medicaid, the income and resources of that child are not used in determining eligibility of the eligible group and the ineligible child is not a part of the household size. However, the income and resources of a parent who is ineligible for Medicaid are used in determining eligibility of the eligible group and the ineligible parent is counted when determining household size.

441—75.59(249A) Persons who may be voluntarily excluded from the eligible group when determining eligibility for the family medical assistance program (FMAP) and FMAP-related coverage groups.

75.59(1) Exclusions from the eligible group. In determining eligibility under the family medical assistance program (FMAP) or any FMAP-related Medicaid coverage group in this chapter, the following persons may be excluded from the eligible group when determining Medicaid eligibility of other household members.

a. Siblings (of whole or half blood, or adoptive) of eligible children.

b. Self-supporting parents of minor unmarried parents.

c. Stepparents of eligible children.

d. Children living with a specified relative, as listed at subrule 75.55(1).

75.59(2) Needs, income, and resource exclusions. The needs, income, and resources of persons who are voluntarily excluded shall also be excluded. If a self-supporting parent of a minor unmarried parent is voluntarily excluded, then the minor unmarried parent shall not be counted in the household size when determining eligibility for the minor unmarried parent’s child. However, the income and resources of the minor unmarried parent shall be used in determining eligibility for the unmarried minor parent’s child. If a stepparent is voluntarily excluded, the natural or adoptive parent shall not be counted in the household size when determining eligibility for the natural or adoptive parent’s children. However, the income and resources of the natural or adoptive parent shall be used in determining eligibility for the natural or adoptive parent’s children.

75.59(3) Medicaid entitlement. Persons whose needs are voluntarily excluded from the eligibility determination shall not be entitled to Medicaid under this or any other coverage group.
75.59(4) **Situations where parent’s needs are excluded.** In situations where the parent’s needs are excluded but the parent’s income and resources are considered in the eligibility determination (e.g., minor unmarried parent living with self-supporting parents), the excluded parent shall be allowed the earned income deduction, child care expenses and the work incentive disregard as provided at paragraphs 75.57(2) “a,” “b,” and “c.”

75.59(5) **Situations where child’s needs, income, and resources are excluded.** In situations where the child’s needs, income, and resources are excluded from the eligibility determination pursuant to subrule 75.59(1), and the child’s income is not sufficient to meet the child’s needs, the parent shall be allowed to divert income to meet the unmet needs of the excluded child. The maximum amount to be diverted shall be the difference between the schedule of basic needs of the eligible group with the child included and the schedule of basic needs with the child excluded, in accordance with the provisions of subrule 75.58(2), minus any countable income of the child.

441—75.60(249A) **Pending SSI approval.** When a person who would ordinarily be in the eligible group has applied for supplemental security income benefits, the person’s needs may be included in the eligible group pending approval of supplemental security income.

441—75.61 to 75.69  Reserved.

**DIVISION III**

FINANCIAL ELIGIBILITY BASED ON MODIFIED ADJUSTED GROSS INCOME (MAGI)

441—75.70(249A) **Financial eligibility based on modified adjusted gross income (MAGI).** Notwithstanding any other provision of this chapter, effective January 1, 2014, financial eligibility for medical assistance shall be determined using “modified adjusted gross income” (MAGI) and “household income” pursuant to 42 U.S.C. § 1396a(e)(14), to the extent required by that section as a condition of federal funding under Title XIX of the Social Security Act. For this purpose, financial eligibility for medical assistance includes any applicable purpose for which a determination of income is required, including the imposition of any premiums or cost sharing.

[ARC 1134C, IAB 10/30/13, effective 10/2/13; ARC 1212C, IAB 12/11/13, effective 1/1/14; ARC 1356C, IAB 3/5/14, effective 4/9/14; ARC 3354C, IAB 10/11/17, effective 10/1/17; ARC 3550C, IAB 1/3/18, effective 2/7/18]

441—75.71(249A) **Income limits.** Notwithstanding any other provision of this chapter, effective January 1, 2014, the following income limits apply to the following coverage groups, as identified by the legal references provided:
<table>
<thead>
<tr>
<th>Coverage Group</th>
<th>Legal Reference</th>
<th>Household Size (persons)</th>
<th>Income Limit (per month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Medical Assistance Program and Child Medical Assistance Program</td>
<td>441—subrule 75.1(14) and 441—subrule 75.1(15); 42 CFR Part 435.110; Title XIX of the Social Security Act, Section 1931</td>
<td>1</td>
<td>$447</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>$716</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>$872</td>
</tr>
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<td></td>
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<td>5</td>
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<td></td>
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<td>6</td>
<td>$1,330</td>
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<tr>
<td></td>
<td></td>
<td>7</td>
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<td></td>
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<td>8</td>
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<tr>
<td></td>
<td></td>
<td>9</td>
<td>$1,784</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10</td>
<td>$1,950</td>
</tr>
<tr>
<td></td>
<td></td>
<td>over 10</td>
<td>$1,950 plus $178 for each additional person</td>
</tr>
<tr>
<td>Mothers and Children, for pregnant women and for infants under one year of age</td>
<td>441—subrule 75.1(28); 42 CFR Part 435.116; Title XIX of the Social Security Act, Section 1902</td>
<td>375% of the federal poverty level for the household</td>
<td></td>
</tr>
<tr>
<td>Mothers and Children, for children aged 1 through 18 years</td>
<td>441—subrule 75.1(28); 42 CFR Part 435.116; Title XIX of the Social Security Act, Section 1902</td>
<td>167% of the federal poverty level for the household</td>
<td></td>
</tr>
<tr>
<td>Medicaid for Independent Young Adults</td>
<td>441—subrule 75.1(42); Title XIX of the Social Security Act, Section 1902(a)(10)(A)(ii)(VII)</td>
<td>254% of the federal poverty level for the household</td>
<td></td>
</tr>
</tbody>
</table>

[ARC 1134C, IAB 10/30/13, effective 10/2/13; ARC 1212C, IAB 12/11/13, effective 1/1/14; ARC 1356C, IAB 3/5/14, effective 4/9/14]

These rules are intended to implement Iowa Code section 249A.4.

[Filed 3/11/70; amended 12/17/73, 5/16/74, 7/1/74]
[Filed emergency 1/16/76—published 2/9/76, effective 2/1/76]
[Filed emergency 1/29/76—published 2/9/76, effective 1/29/76]
[Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]
[Filed 1/31/77, Notice 12/1/76—published 2/23/77, effective 3/30/77]
[Filed emergency 6/22/77—published 7/13/77, effective 7/1/77]
[Filed 12/6/77, Notice 10/19/77—published 12/28/77, effective 2/1/78]
[Filed emergency 6/28/78—published 7/26/78, effective 7/1/78]
[Filed emergency 7/28/78 after Notice 4/19/78—published 8/23/78, effective 7/28/78]
[Filed 8/9/78, Notice 6/28/78—published 9/6/78, effective 10/11/78]
[Filed emergency 6/26/79—published 7/25/79, effective 7/1/79]
[Filed emergency 5/5/80—published 5/28/80, effective 5/5/80]
[Filed emergency 6/30/80—published 7/23/80, effective 7/1/80]
[Filed without Notice 9/25/80—published 10/15/80, effective 12/1/80]
[Filed 12/19/80, Notice 10/15/80—published 1/7/81, effective 2/11/81]
[Filed emergency 6/30/81—published 7/22/81, effective 7/1/81]
[Filed 9/25/81, Notice 7/22/81—published 10/14/81, effective 11/18/81]
[Filed 1/28/82, Notice 10/28/81—published 2/17/82, effective 4/1/82]
[Filed 1/28/82, Notice 12/9/81—published 2/17/82, effective 4/1/82]
[Filed emergency 3/26/82—published 4/14/82, effective 4/1/82]
[Filed emergency 5/21/82—published 6/9/82, effective 6/1/82]
[Filed emergency 5/21/82—published 6/9/82, effective 7/1/82]
[Filed emergency 7/30/82—published 8/18/82, effective 8/1/82]
[Filed 9/23/82, Notices 6/9/82, 8/4/82—published 10/13/82, effective 12/1/82]
[Filed emergency 3/18/83—published 4/13/83, effective 4/1/83]
[Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]
[Filed emergency 9/26/83—published 10/12/83, effective 10/1/83]
[Filed 10/28/83, Notice 9/14/83—published 11/23/83, effective 1/1/84]
[Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
[Filed 12/16/83, Notice 11/9/83—published 1/4/84, effective 2/8/84]
[Filed emergency 1/13/84—published 2/1/84, effective 2/8/84]
[Filed emergency 8/31/84—published 9/26/84, effective 10/1/84]
[Filed emergency 9/28/84—published 10/24/84, effective 10/1/84]
[Filed emergency 1/17/85—published 2/13/85, effective 1/17/85]
[Filed without Notice 1/22/85—published 2/13/85, effective 4/1/85]
[Filed emergency 3/22/85—published 4/10/85, effective 4/1/85]
[Filed 3/22/85, Notice 2/13/85—published 4/10/85, effective 6/1/85]
[Filed 4/29/85, Notice 10/24/84—published 5/22/85, effective 7/1/85]
[Filed 10/1/85, Notice 7/31/85—published 10/23/85, effective 12/1/85]
[Filed 2/21/86, Notice 1/15/86—published 3/12/86, effective 5/1/86]
[Filed emergency 3/21/86 after Notice 2/12/86—published 4/9/86, effective 4/1/86]
[Filed emergency 4/28/86—published 5/21/86, effective 5/1/86]
[Filed emergency 8/28/86—published 9/24/86, effective 9/1/86]
[Filed 9/5/86, Notice 6/18/86—published 9/24/86, effective 11/1/86]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed without Notice 1/15/87—published 2/11/87, effective 4/1/87]
[Filed 3/3/87, Notice 12/31/86—published 3/25/87, effective 5/1/87]
[Filed 3/26/87, Notice 2/11/87—published 4/22/87, effective 6/1/87]
[Filed 4/29/87, Notice 3/11/87—published 5/20/87, effective 7/1/87]
[Filed emergency 5/29/87 after Notice 4/22/87—published 6/17/87, effective 7/1/87]
[Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]
[Filed emergency after Notice 9/24/87, Notice 8/12/87—published 10/21/87, effective 10/1/87]
[Filed 9/24/87, Notice 8/12/87—published 10/21/87, effective 12/1/87]
[Filed emergency after Notice 10/23/87, Notice 9/9/87—published 11/18/87, effective 11/1/87]
[Filed 10/23/87, Notice 9/9/87—published 11/18/87, effective 1/1/88]
[Filed 1/21/88, Notice 12/16/87—published 2/10/88, effective 4/1/88]
[Filed emergency 3/16/88—published 4/6/88, effective 3/16/88]
[Filed emergency 4/22/88—published 5/18/88, effective 5/1/88]
[Filed without Notice 9/21/88—published 10/19/88, effective 12/1/88]
[Filed 10/27/88, Notice 8/24/88—published 11/16/88, effective 1/1/89]
[Filed emergency 11/14/88—published 11/30/88, effective 11/14/88]
[Filed emergency 12/8/88 after Notices 10/19/88, 11/2/88—published 12/28/88, effective 1/1/89]
[Filed 4/13/89, Notice 2/22/89—published 5/3/89, effective 7/1/89]
[Filed 5/10/89, Notice 4/5/89—published 5/31/89, effective 8/1/89]
[Filed 7/14/93, Notice 5/12/93—published 8/4/93, effective 10/1/93]
[Filed 8/12/93, Notice 7/7/93—published 9/1/93, effective 11/1/93]
[Filed emergency 9/17/93—published 10/13/93, effective 10/1/93]
[Filed 9/17/93, Notice 7/21/93—published 10/13/93, effective 12/1/93]
[Filed emergency 11/12/93—published 12/8/93, effective 1/1/94]
[Filed emergency 12/16/93—published 1/5/94, effective 1/1/94]
[Filed without Notice 12/16/93—published 1/5/94, effective 2/9/94]
[Filed 12/16/93, Notices 10/13/93, 10/27/93—published 1/5/94, effective 3/1/94]
[Filed 2/10/94, Notices 12/8/93, 1/5/94—published 3/2/94, effective 5/1/94]
[Filed 3/10/94, Notice 2/2/94—published 3/30/94, effective 6/1/94]
[Filed 4/14/94, Notice 2/16/94—published 5/11/94, effective 7/1/94]
[Filed 9/15/94, Notice 8/3/94—published 10/12/94, effective 11/16/94]
[Filed 10/12/94, Notice 8/17/94—published 11/9/94, effective 1/1/95]
[Filed emergency 12/15/94—published 1/4/95, effective 1/1/95]
[Filed 2/16/95, Notices 11/23/94, 12/21/94, 1/4/95—published 3/15/95, effective 5/1/95]
[Filed 4/13/95, Notices 2/15/95, 3/1/95—published 5/10/95, effective 7/1/95]
[Filed emergency 9/25/95—published 10/11/95, effective 10/1/95]
[Filed 11/16/95, Notices 9/27/95, 10/11/95—published 12/6/95, effective 2/1/96]
[Filed emergency 12/12/95—published 1/3/96, effective 1/1/96]
[Filed 12/12/95, Notice 10/25/95—published 1/3/96, effective 3/1/96]
[Filed 2/14/96, Notice 1/3/96—published 3/13/96, effective 5/1/96]
[Filed 4/10/96, Notice 2/14/96—published 5/8/96, effective 7/1/96]
[Filed emergency 9/19/96—published 10/9/96, effective 9/19/96]
[Filed 10/9/96, Notice 8/28/96—published 11/6/96, effective 1/1/97]
[Filed emergency 12/12/96—published 1/1/97, effective 1/1/97]

[Filed 12/12/96, Notices 9/11/96, 10/9/96—published 1/1/97, effective 3/1/97]
[Filed 2/12/97, Notice 1/1/97—published 3/12/97, effective 5/1/97]
[Filed 3/12/97, Notice 1/1/97—published 4/9/97, effective 6/1/97]
[Filed 4/11/97, Notice 2/26/97—published 5/7/97, effective 7/1/97]
[Filed emergency 9/16/97—published 10/8/97, effective 10/1/97]
[Filed 9/16/97, Notice 7/16/97—published 10/8/97, effective 12/1/97]
[Filed emergency 12/10/97—published 12/31/97, effective 1/1/98]

[Filed emergency 12/10/97 after Notices 10/22/97, 11/5/97—published 12/31/97, effective 1/1/98]
[Filed emergency 1/14/98 after Notice 11/19/97—published 2/11/98, effective 2/1/98]
[Filed 3/11/98, Notice 1/14/98—published 4/8/98, effective 6/1/98]
[Filed emergency 6/10/98—published 7/1/98, effective 7/1/98]
[Filed emergency 6/25/98—published 7/15/98, effective 7/1/98]
[Filed 7/15/98, Notices 6/3/98—published 8/12/98, effective 10/1/98]
[Filed 8/12/98, Notices 6/17/98, 7/1/98—published 9/9/98, effective 11/1/98]
[Filed 9/15/98, Notice 7/15/98—published 10/7/98, effective 12/1/98]
[Filed 11/10/98, Notice 9/23/98—published 12/2/98, effective 2/1/99]
[Filed emergency 12/9/98—published 12/30/98, effective 1/1/99]
[Filed 2/10/99, Notice 12/30/98—published 3/10/99, effective 4/15/99]
[Filed 3/10/99, Notice 11/18/98—published 4/7/99, effective 6/1/99]
[Filed 3/10/99, Notice 1/27/99—published 4/7/99, effective 7/1/99]
[Filed 4/15/99, Notice 2/10/99—published 5/5/99, effective 7/1/99]
[Filed 5/14/99, Notice 4/7/99—published 6/2/99, effective 8/1/99]
[Filed 10/21/05, Notice 8/31/05—published 11/9/05, effective 1/1/06]
[Filed emergency 11/16/05—published 12/7/05, effective 12/1/05]
[Filed emergency 12/14/05—published 1/4/06, effective 1/1/06]
[Filed emergency 1/12/06 after Notice 11/23/05—published 2/1/06, effective 2/1/06]
[Filed 2/10/06, Notice 1/4/06—published 3/1/06, effective 4/5/06]
[Filed without Notice 4/17/06—published 5/10/06, effective 7/1/06]
[Filed emergency 5/12/06—published 6/7/06, effective 6/1/06]
[Filed emergency 6/16/06 after Notice 4/12/06—published 7/5/06, effective 7/1/06]
[Filed emergency 6/16/06 after Notice 5/10/06—published 7/5/06, effective 7/1/06]
[Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]
[Filed 7/14/06, Notice 6/7/06—published 8/2/06, effective 9/6/06]
[Filed 10/20/06, Notice 8/2/06—published 11/8/06, effective 1/1/07]
[Filed 11/8/06, Notice 7/5/06—published 12/6/06, effective 1/10/07]
[Filed 12/13/06, Notice 7/5/06—published 1/3/07, effective 2/7/07]
[Filed 4/11/07, Notice 2/28/07—published 5/9/07, effective 7/1/07]
[Filed 5/16/07, Notice 2/14/07—published 6/6/07, effective 8/1/07]
[Filed emergency 6/13/07—published 7/4/07, effective 7/1/07]
[Filed emergency 6/15/07—published 7/4/07, effective 7/1/07]
[Filed emergency 6/13/07—published 7/4/07, effective 8/1/07]
[Filed emergency 7/12/07 after Notice 5/9/07—published 8/1/07, effective 8/1/07]
[Filed 9/12/07, Notice 7/4/07—published 10/10/07, effective 11/14/07]
[Filed emergency 10/10/07 after Notice 8/29/07—published 11/7/07, effective 11/1/07]
[Filed 12/12/07, Notice 7/4/07—published 1/2/08, effective 2/6/08]
[Filed emergency 1/9/08 after Notice 12/5/07—published 1/30/08, effective 2/1/08]
[Filed emergency 2/13/08 after Notice 12/19/07—published 3/12/08, effective 2/15/08]
[Filed emergency 3/12/08—published 4/9/08, effective 3/12/08]
[Filed 4/10/08, Notice 1/30/08—published 5/7/08, effective 7/1/08]
[Filed 4/10/08, Notice 2/27/08—published 5/7/08, effective 7/1/08]
[Filed emergency 6/11/08—published 7/2/08, effective 7/1/08]
[Filed 6/11/08, Notice 4/9/08—published 7/2/08, effective 8/6/08]
[Filed 7/9/08, Notice 5/7/08—published 7/30/08, effective 10/1/08]
[Filed emergency 10/14/08 after Notice 7/2/08—published 11/5/08, effective 11/1/08]
[Filed emergency 10/14/08 after Notice 8/27/08—published 11/5/08, effective 11/1/08]
[Filed emergency 11/12/08 after Notice 9/24/08—published 12/3/08, effective 1/1/09]
[Filed 11/12/08, Notice 8/13/08—published 12/3/08, effective 2/1/09]
[Filed ARC 7546B (Notice ARC 7356B, IAB 11/19/08), IAB 2/11/09, effective 4/1/09]
[Filed ARC 7741B (Notice ARC 7526B, IAB 1/28/09), IAB 5/6/09, effective 7/1/09]
[Filed ARC 7834B (Notice ARC 7630B, IAB 3/11/09), IAB 6/3/09, effective 7/8/09]
[Filed ARC 7833B (Notice ARC 7629B, IAB 3/11/09), IAB 6/3/09, effective 8/1/09]
[Filed Emergency ARC 7929B, IAB 7/1/09, effective 7/1/09]
[Filed Emergency ARC 7931B, IAB 7/1/09, effective 7/1/09]
[Filed Emergency ARC 7932B, IAB 7/1/09, effective 7/1/09]
[Filed ARC 7935B (Notice ARC 7718B, IAB 4/22/09), IAB 7/1/09, effective 9/1/09]
[Filed ARC 8095B (Notice ARC 7930B, IAB 7/1/09), IAB 9/9/09, effective 10/14/09]
[Filed ARC 8096B (Notice ARC 7934B, IAB 7/1/09), IAB 9/9/09, effective 10/14/09]
[Filed ARC 8260B (Notice ARC 8056B, IAB 8/26/09), IAB 11/4/09, effective 1/1/10]
[Filed Emergency After Notice ARC 8261B, IAB 11/4/09, effective 10/15/09]
[Filed ARC 8439B (Notice ARC 8083B, IAB 8/26/09), IAB 1/13/10, effective 3/1/10]
[Filed ARC 8443B (Notice ARC 8220B, IAB 10/7/09), IAB 1/13/10, effective 3/1/10]
[Filed ARC 8444B (Notice ARC 8221B, IAB 10/7/09), IAB 1/13/10, effective 3/1/10]
[Filed Emergency After Notice ARC 8503B (Notice ARC 8311B, IAB 11/18/09), IAB 2/10/10, effective 1/13/10]
[Filed Emergency After Notice ARC 8500B (Notice ARC 8272B, IAB 11/4/09), IAB 2/10/10, effective 3/1/10]
[Filed Emergency After Notice ARC 8556B (Notice ARC 8407B, IAB 12/16/09), IAB 3/10/10, effective 2/10/10]
[Filed ARC 8642B (Notice ARC 8461B, IAB 1/13/10), IAB 4/7/10, effective 6/1/10]
[Filed Without Notice ARC 8713B, IAB 5/5/10, effective 8/1/10]
[Filed Emergency After Notice ARC 8786B (Notice ARC 8552B, IAB 2/24/10), IAB 6/2/10, effective 6/1/10]
[Filed ARC 8785B (Notice ARC 8619B, IAB 3/24/10), IAB 6/2/10, effective 8/1/10]
[Filed Emergency ARC 8892B, IAB 6/30/10, effective 7/1/10]
[Filed ARC 8897B (Notice ARC 8705B, IAB 4/21/10), IAB 6/30/10, effective 9/1/10]
[Filed ARC 9043B (Notice ARC 8853B, IAB 6/16/10), IAB 9/8/10, effective 11/1/10]
[Filed ARC 9044B (Notice ARC 8864B, IAB 6/16/10), IAB 9/8/10, effective 11/1/10]
[Filed ARC 9404B (Notice ARC 9277B, IAB 12/15/10), IAB 3/9/11, effective 5/1/11]
[Filed ARC 9439B (Notice ARC 9309B, IAB 12/29/10), IAB 4/6/11, effective 6/1/11]
[Filed Emergency ARC 9582B, IAB 6/29/11, effective 7/1/11]
[Filed ARC 9581B (Notice ARC 9479B, IAB 4/20/11), IAB 6/29/11, effective 8/3/11]
[Filed Emergency ARC 9647B, IAB 8/10/11, effective 8/1/11]
[Filed Emergency ARC 9696B, IAB 9/7/11, effective 9/1/11]
[Filed ARC 9881B (Notice ARC 9697B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]
[Filed Emergency After Notice ARC 9956B (Notice ARC 9648B, IAB 8/10/11), IAB 1/11/12, effective 1/1/12]
[Filed Emergency After Notice ARC 9957B (Notice ARC 9804B, IAB 10/19/11), IAB 1/11/12, effective 1/1/12]
[Filed ARC 0149C (Notice ARC 0047C, IAB 3/21/12), IAB 6/13/12, effective 8/1/12]
[Filed Emergency ARC 0192C, IAB 7/11/12, effective 7/1/12]
[Filed ARC 0579C (Notice ARC 0432C, IAB 10/31/12), IAB 2/6/13, effective 4/1/13]
[Filed Emergency After Notice ARC 0822C (Notice ARC 0690C, IAB 4/17/13), IAB 7/10/13, effective 7/1/13]
[Filed Emergency After Notice ARC 0821C (Notice ARC 0691C, IAB 4/17/13), IAB 7/10/13, effective 7/1/13]
[Filed Emergency After Notice ARC 0820C (Notice ARC 0668C, IAB 4/3/13), IAB 7/10/13, effective 8/1/13]
[Filed ARC 0990C (Notice ARC 0746C, IAB 5/15/13), IAB 9/4/13, effective 1/1/14]
[Filed Emergency After Notice ARC 1134C (Notice ARC 0971C, IAB 8/21/13), IAB 10/30/13, effective 10/2/13]
[Filed Emergency After Notice ARC 1212C, IAB 12/11/13, effective 1/1/14]
[Filed Emergency ARC 1266C, IAB 1/8/14, effective 1/1/14]
[Filed ARC 1355C (Notice ARC 1265C, IAB 1/8/14), IAB 3/5/14, effective 4/9/14]
[Filed ARC 1356C (Notice ARC 1211C, IAB 12/11/13), IAB 3/5/14, effective 4/9/14]
[Filed ARC 1447C (Notice ARC 1368C, IAB 3/5/14), IAB 4/30/14, effective 7/1/14]
[Filed Emergency After Notice ARC 1484C (Notice ARC 1415C, IAB 4/2/14), IAB 6/11/14, effective 7/1/14]
[Filed Emergency After Notice ARC 1483C (Notice ARC 1416C, IAB 4/2/14), IAB 6/11/14, effective 7/1/14]
[Filed ARC 1482C (Notice ARC 1417C, IAB 4/2/14), IAB 6/11/14, effective 8/1/14]
[Filed Emergency After Notice ARC 2027C (Notice ARC 1952C, IAB 4/1/15), IAB 6/10/15, effective 7/1/15]
[Filed ARC 2029C (Notice ARC 1951C, IAB 4/1/15), IAB 6/10/15, effective 8/1/15]
[Filed Emergency After Notice ARC 2361C (Notice ARC 2242C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]
[Filed ARC 2557C (Notice ARC 2469C, IAB 3/30/16), IAB 6/8/16, effective 8/1/16]
[Filed Emergency After Notice ARC 2605C (Notice ARC 2505C, IAB 4/27/16), IAB 7/6/16, effective 7/1/16]
[Filed ARC 3094C (Notice ARC 3001C, IAB 3/29/17), IAB 6/7/17, effective 8/1/17]
[Filed Emergency After Notice ARC 3182C (Notice ARC 3016C, IAB 4/12/17), IAB 7/5/17, effective 7/1/17]
[Filed Emergency After Notice ARC 3183C (Notice ARC 3017C, IAB 4/12/17), IAB 7/5/17, effective 7/1/17]
[Filed Emergency ARC 3353C, IAB 10/11/17, effective 10/1/17]
[Filed Emergency ARC 3354C, IAB 10/11/17, effective 10/1/17]
[Filed ARC 3493C (Notice ARC 3323C, IAB 9/27/17), IAB 12/6/17, effective 1/10/18]
[Filed ARC 3549C (Notice ARC 3355C, IAB 10/11/17), IAB 1/3/18, effective 2/7/18]
[Filed ARC 3550C (Notice ARC 3356C, IAB 10/11/17), IAB 1/3/18, effective 2/7/18]
[Filed Emergency After Notice ARC 3869C (Notice ARC 3760C, IAB 4/25/18), IAB 7/4/18, effective 7/1/18]
[Filed Emergency After Notice ARC 3870C (Notice ARC 3761C, IAB 4/25/18), IAB 7/4/18, effective 7/1/18]
[Filed ARC 3873C (Notice ARC 3704C, IAB 3/28/18), IAB 7/4/18, effective 8/8/18]
[Filed ARC 4208C (Notice ARC 4106C, IAB 11/7/18), IAB 1/2/19, effective 2/6/19]
[Filed Emergency After Notice ARC 4572C (Notice ARC 4443C, IAB 5/22/19), IAB 7/31/19, effective 7/11/19]
[Filed ARC 4574C (Notice ARC 4442C, IAB 5/22/19), IAB 7/31/19, effective 9/4/19]

◊ Two or more ARCs
1 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.
CHAPTER 78
AMOUNT, DURATION AND SCOPE OF
MEDICAL AND REMEDIAL SERVICES

[Prior to 7/1/83, Social Services[770] Ch 78]
[Prior to 2/11/87, Human Services[498]]

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

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

78.1(1) Payment will not be made for:

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

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

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

d. Acupuncture treatments.

e. Rescinded 9/6/78.

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

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

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

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

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

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

(1) Colostomy and ileostomy appliances.

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

(3) Disposable irrigation trays or sets.

(4) Disposable catheterization trays or sets.

(5) Indwelling Foley catheter.

(6) Disposable saline enemas.

(7) Diabetic supplies including needles and syringes, blood glucose test strips, and diabetic urine test supplies.
c. Prescription records are required for all drugs as specified in Iowa Code sections 124.308, 155A.27 and 155A.29. For the purposes of the medical assistance program, prescriptions for medical supplies are required and shall be subject to the same provisions.

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Correction of a congenital anomaly; or
(2) Restoration of body form following an accidental injury; or
(3) Revision of disfiguring and extensive scars resulting from neoplastic surgery.

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

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

(1) Dental congenital anomalies, such as absent tooth buds, malocclusion, and similar conditions.
(2) Procedures related to transsexualism, hermaphroditism, gender identity disorders, or body dysmorphic disorders.

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

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

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

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

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

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

(3) Augmentation mammoplasties.

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

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

(6) Panniculectomy and body sculpture procedures.

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

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

(9) Chemical peeling for facial wrinkles.

(10) Dermabrasion of the face.

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

(12) Removal of tattoos.

(13) Hair transplants.

(14) Electrolysis.

(15) Sex reassignment.

(16) Penile implant procedures.

(17) Insertion of prosthetic testicles.

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

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

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

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

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

78.1(9) Payment will be approved for visits to patients in nursing facilities subject to the following conditions:
a. Payment will be approved for only one visit to the same patient in a calendar month. Payment for further visits will be made only when the need for the visits is adequately documented by the physician.

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

c. Payment will be approved for mileage in connection with nursing home visits when:
   (1) It is necessary for the physician to travel outside the home community, and
   (2) There are not physicians in the community in which the nursing home is located.

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

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

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

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

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

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

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

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

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

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

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

d. Services incident to the professional services of the physician means the service provided by the auxiliary person must be related to the physician’s professional service to the member. If the physician
has not or will not perform a personal professional service to the member, the clinical records must document that the physician assigned treatment of the member to the auxiliary person.

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

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

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

a. The following definitions are pertinent to this subrule:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

f. At least 30 days and not more than 180 days shall have elapsed following the signing of the informed consent except in the case of premature delivery or emergency abdominal surgery which occurs
not less than 72 hours after the informed consent was signed. The informed consent shall have been signed at least 30 days before the expected delivery date for premature deliveries.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

78.1(19) Preprocedure review by the 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 I [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. A history of frequent, acute, and severe metabolic complications (e.g., hypoglycemia, hyperglycemia, or ketoacidosis) requiring medical attention.

   b. Clinical problems with exogenous insulin therapy that are so severe as to be incapacitating.

   c. Consistent failure of insulin-based management to prevent acute complications.

   The pancreas transplants listed under this subparagraph require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1)“f””)
Covered transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

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

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

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

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

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

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

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

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

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

78.1(24) Topical fluoride varnish. Payment shall be made for application of an FDA-approved topical fluoride varnish, as defined by the current version of the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association, for the purpose of preventing the worsening of early childhood caries in children aged 0 to 36 months of age, whenrendered 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.

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]

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

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

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

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

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

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

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

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

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

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

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

b. Payment is not made for:

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

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

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

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

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

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

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

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

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

(10) Prescription drugs for which the prescription was executed in written (and nonelectronic) form unless the prescription was executed on a tamper-resistant pad, as required by Section 1903(i)(23) of the Social Security Act (42 U.S.C. Section 1396b(i)(23)).
(11) Drugs used for symptomatic relief of cough and colds, except for nonprescription drugs listed at subrule 78.2(5).

(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 325 mg, 650 mg, 81 mg (chewable)
- Aspirin tablets, enteric coated 325 mg, 650 mg, 81 mg
- Aspirin tablets, buffered 325 mg
- Bacitracin ointment 500 units/gm
- Benzoyl peroxide 5%, gel, lotion
- Benzoyl peroxide 10%, gel, lotion
- Calcium carbonate chewable tablets 500 mg, 750 mg, 1000 mg, 1250 mg
- Calcium carbonate suspension 1250 mg/5 ml
- Calcium carbonate tablets 600 mg
- Calcium carbonate-vitamin D tablets 500 mg-200 units
- Calcium carbonate-vitamin D tablets 600 mg-200 units
- Calcium citrate tablets 950 mg (200 mg elemental calcium)
- Calcium gluconate tablets 650 mg
- Calcium lactate tablets 650 mg
- Cetirizine hydrochloride liquid 1 mg/ml
- Cetirizine hydrochloride tablets 5 mg
- Cetirizine hydrochloride tablets 10 mg
- Chlorpheniramine maleate tablets 4 mg
- Clotrimazole vaginal cream 1%
- Diphenhydramine hydrochloride capsules 25 mg
- Diphenhydramine hydrochloride elixir, liquid, and syrup 12.5 mg/5 ml
- Epinephrine racemic solution 2.25%
- Ferrous sulfate tablets 325 mg
- Ferrous sulfate elixir 220 mg/5 ml
- Ferrous sulfate drops 75 mg/0.6 ml
- Ferrous gluconate tablets 325 mg
- Ferrous fumarate tablets 325 mg
- Guaifenesin 100 mg/5 ml with dextromethorphan 10 mg/5 ml liquid
- Ibuprofen suspension 100 mg/5 ml
- Ibuprofen tablets 200 mg
- Insulin
- Lactic acid (ammonium lactate) lotion 12%
- Loperamide hydrochloride liquid 1 mg/5 ml
- Loperamide hydrochloride tablets 2 mg
- Loratadine syrup 5 mg/5 ml
- Loratadine tablets 10 mg
- Magnesium hydroxide suspension 400 mg/5 ml
Magnesium oxide capsule 140 mg (85 mg elemental magnesium)
Magnesium oxide tablets 400 mg
Meclizine hydrochloride tablets 12.5 mg, 25 mg oral and chewable
Miconazole nitrate cream 2% topical and vaginal
Miconazole nitrate vaginal suppositories, 100 mg
Multiple vitamin and mineral products with prior authorization
Neomycin-bacitracin-polymyxin ointment
Niacin (nicotinic acid) tablets 50 mg, 100 mg, 250 mg, 500 mg
Nicotine gum 2 mg, 4 mg
Nicotine lozenge 2 mg, 4 mg
Nicotine patch 7 mg/day, 14 mg/day and 21 mg/day
Pediatric oral electrolyte solutions
Permethrin lotion 1%
Polyethylene glycol 3350 powder
Pseudoephedrine hydrochloride tablets 30 mg, 60 mg
Pseudoephedrine hydrochloride liquid 30 mg/5 ml
Pyrethrins-piperonyl butoxide liquid 0.33-4%
Pyrethrins-piperonyl butoxide shampoo 0.3-3%
Pyrethrins-piperonyl butoxide shampoo 0.33-4%
Salicylic acid liquid 17%
Senna tablets 187 mg
Sennosides-docusate sodium tablets 8.6 mg-50 mg
Sennosides syrup 8.8 mg/5 ml
Sennosides tablets 8.6 mg
Sodium bicarbonate tablets 325 mg
Sodium bicarbonate tablets 650 mg
Sodium chloride hypertonic ophthalmic ointment 5%
Sodium chloride hypertonic ophthalmic solution 5%
Tolnaftate 1% cream, solution, powder
Other nonprescription drugs listed as preferred in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

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 and dispensed.

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

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

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

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

This rule is intended to implement Iowa Code section 249A.4.
441—78.3(249A) Inpatient hospital services. Payment for inpatient hospital admission is approved when it meets the criteria for inpatient hospital care as determined by the Iowa Medicaid enterprise. All cases are subject to random retrospective review and may be subject to a more intensive retrospective review if abuse is suspected. In addition, transfers, outliers, and readmissions within 31 days are subject to random review. Selected admissions and procedures are subject to a 100 percent review before the services are rendered. Medicaid payment for inpatient hospital admissions and continued stays are approved when the admissions and continued stays are determined to meet the criteria for inpatient hospital care. (Cross reference 78.28(5)) The criteria are available from the IME Medical Services Unit, 100 Army Post Road, Des Moines, Iowa 50315, or in local hospital utilization review offices. No payment will be made for waiver days.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Recipient selection and education.

(1) Selection. The transplant center must have written criteria based on medical need for transplantation for final facility selection of recipients. These criteria should include an equitable, consistent and practical protocol for selection of recipients. The criteria must be at least as strict as those specified by Medicare.
(2) **Education.** The transplant center will provide a written plan for recipient education. It shall include educational plans for recipient, family and significant others during all phases of the program. These phases shall include:
- Intake.
- Preparation and waiting period.
- Preadmission.
- Hospitalization.
- Discharge planning.
- Follow-up.

b. **Staffing and resource commitment.**

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

The transplant surgeon will be certified by the American Board of Thoracic Surgery or equivalent for heart transplants and the American Board of Surgery or equivalent for liver transplants. The transplant surgeon will be the defined leader of a stable, established transplant team that has a strong commitment to the transplant program.

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

The team should consist of:
- A surgeon director.
- A board-certified internist or pediatrician with training and expertise in organ transplantation medicine and clinical use of immunosuppressive regimens.

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

(3) **Physicians.** The transplant center will have on staff or available for consultation physicians with the following areas of expertise:
- Anesthesiology.
- Cardiology.
- Dialysis.
- Gastroenterology.
- Hepatology.
- Immunology.
- Infectious diseases.
- Nephrology.
- Neurology.
- Pathology.
- Pediatrics.
- Psychiatry.
- Pulmonary medicine.
- Radiology.
- Rehabilitation medicine.

Liaison with the recipient’s permanent physician is established for the purpose of providing continuity and management of the recipient’s long-term care.
(4) **Support personnel and resources.** The center must have a commitment of sufficient resources and planning for implementation and operation of the transplant program. Indicators of the commitment will include the following:

Persons with expertise in the following areas available at the transplant center:
- Anesthesiology.
- Blood bank services.
- Cardiology.
- Cardiovascular surgery.
- Dialysis.
- Dietary services.
- Gastroenterology.
- Infection control.
- Laboratory services (pathology, microbiology, immunology, tissue typing, and monitoring of immunosuppressive drugs).
- Legal counsel familiar with transplantation laws and regulations.
- Nursing service department with staff available who have expertise in the care of transplant recipients, especially in managing immunosuppressed patients and hemodynamic support.
- Respiratory therapy.
- Pharmaceutical services.
- Physical therapy.
- Psychiatry.
- Psycho-social.

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

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

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

C. **Experience and survival rates.**

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

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

2. **Survival rates.** The transplant center will achieve a record of acceptable performance consistent with the performance and outcomes at other successful designated transplant centers. The center will collect and maintain recipient and graft survival and complication rates. A level of satisfactory success and safety will be demonstrated with bases for substantial probability of continued performance at an acceptable level.
To encourage a high level of performance, transplant programs must achieve and maintain a minimum one-year patient survival rate of 70 percent for heart transplants and 50 percent for liver transplants.

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

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

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

\(e\). **Maintenance of data, research, review and evaluation.**

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

- Risk and benefit.
- Morbidity and mortality.
- Long-term survival.
- Quality of life.
- Recipient demographic information.

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

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

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

Ongoing research regarding the transplanted organs is required.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

78.3(13) Payment for patients in acute hospital beds who are determined by 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—paragraph 81.6(16)”f”(3) plus the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—paragraph 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—paragraph 81.6(16)”f”(1) plus the non-direct care rate component limit for Medicaid nursing facilities pursuant to 441—paragraph 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—paragraph 81.6(16)”f”(3) and the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—paragraph 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.
      4. 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.
      5. A Medicaid member who has been in a swing bed beyond 14 days must be discharged to an appropriate nursing facility bed within a 30-mile radius of the swing-bed hospital or to appropriate home-based care within 72 hours of an appropriate nursing facility bed becoming available.

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

   78.3(17) Rescinded IAB 8/9/89, effective 10/1/89.
   78.3(18) Preprocedure review by the IME medical services unit is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Preprocedure review is also required for other types of major surgical procedures, such as organ transplants. Criteria are available from the IME medical services unit. (Cross reference 78.28(5))
   78.3(19) Rescinded IAB 10/8/97, effective 12/1/97.

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 0194C, IAB 7/11/12, effective 7/1/12; ARC 0354C, IAB 10/3/12, effective 12/1/12; ARC 0844C, IAB 7/24/13, effective 7/1/13; ARC 1054C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

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 panographic-type radiography with bite-wings is considered the same as a full mouth radiograph survey.

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

e. Single periapical films are payable when necessary.

f. Intraoral radiograph, occlusal.

g. Extraoral radiograph.

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

i. Temporomandibular joint radiograph.

j. Cephalometric film.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

f. Tissue regeneration procedures require prior authorization. Approval shall be granted when radiographs show evidence of recession in relation to the muco-gingival junction and the bone level indicates the tooth has a fair to good long-term prognosis.
g. Localized delivery of antimicrobial agents requires prior authorization. Approval shall be granted when at least one year has elapsed since periodontal scaling and root planing was completed, the member has maintained regular periodontal maintenance, and pocket depths remain at a moderate to severe depth with bleeding on probing. Authorization is limited to once per site every 12 months.

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

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

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

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

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

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

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

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

a. Extractions, both surgical and nonsurgical.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c. Comprehensive orthodontic treatment when prior approval has been received. Approval is limited to members under 21 years of age and shall be granted when the member has a severe handicapping malocclusion with a score of 26 or above using the index from the “Handicapping Malocclusion Assessment to Establish Treatment Priority,” by J.A. Salzmann, 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.

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

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

a. Durable plantar foot orthotic.

b. Plaster impressions for foot orthotic.

c. Molded digital orthotic.

d. Shoe padding when appliances are not practical.

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

f. Rams horn (hypertrophic) nails.

g. Onychomycosis (mycotic) nails.

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

a. Treatment of flatfoot. The term “flatfoot” is defined as a condition in which one or more arches have flattened out.
b. Treatment of subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot. Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered.

Reasonable and necessary diagnosis of symptomatic conditions that result from or are associated with partial displacement of foot structures is a covered service. Surgical correction in the subluxated foot structure that is an integral part of the treatment of a foot injury or is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition is a covered service.

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

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

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

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

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

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

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

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

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

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

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

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

(2) Gonioscopy.

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

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

(5) External photography.

(6) Fundus photography.

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

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

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

1. Ordering of corrective lenses.
2. Verification of lenses after fabrication.
3. Adjustment and alignment of completed lens order.

(2) New spectacle lenses are subject to the following limitations:

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

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

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

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

  f. Frame service.

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

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

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

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

(3) Safety frames are allowed for:

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

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

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

  i. Contact lenses. Payment shall be made for documented keratoconus, aphakia, high myopia, anisometropia, trauma, severe ocular surface disease, irregular astigmatism, for treatment of acute or chronic eye disease, or when the member’s vision cannot be adequately corrected with spectacle lenses. Contact lenses are subject to the following limitations:
(1) Up to 16 gas permeable contact lenses are allowed for children up to one year of age.
(2) Up to 8 gas permeable contact lenses are allowed every 12 months for children one through
three years of age.
(3) Up to 6 gas permeable contact lenses are allowed every 12 months for children four through
seven years of age.
(4) Two gas permeable contact lenses are allowed every 24 months for members eight years of age
or older.
(5) Soft contact lenses and replacements are allowed when medically necessary.

78.6(2) Ophthalmic materials. Ophthalmic materials which are provided in connection with any
of the foregoing professional optometric services shall provide adequate vision as determined by the
optometrist and meet the following standards:
   a. Corrected curve lenses, unless clinically contraindicated.
   b. Standard plastic, plastic and metal combination, or metal frames.
   c. Prescription standards according to the American National Standards Institute (ANSI) standards
and tolerance.

78.6(3) Reimbursement. The reimbursement for allowed ophthalmic material is subject to a fee
schedule established by the department or to actual laboratory cost as evidenced by an attached invoice.
Reimbursement for rose tint is included in the fee for the lenses.
   a. Materials payable by fee schedule are:
      (1) Spectacle lenses, single vision and multifocal.
      (2) Frames.
      (3) Case for glasses.
   b. Materials payable at actual laboratory cost as evidenced by an attached invoice are:
      (1) Contact lenses.
      (2) Schroeder shield.
      (3) Ptosis crutch.
      (4) Safety frames.
      (5) Subnormal visual aids.
      (6) Photochromatic lenses.

78.6(4) Prior authorization. Prior authorization is required for the following:
   a. A second lens correction within a 24-month period for members eight years of age and older.
   Approval shall be given when the member’s vision has at least a five-tenths diopter of change in sphere
or cylinder or ten-degree change in axis in either eye.
   b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of
time not greater than 90 days. Should continued therapy be warranted, the prior approval process shall
be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are
convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.
   c. Subnormal visual aids where near visual acuity is at or better than 20/100 at 16 inches, 2M
print. Prior authorization is not required if near visual acuity as described above is less than 20/100.
Subnormal visual aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles, or
reverse Galilean telescope systems. Payment shall be actual laboratory cost as evidenced by an attached
invoice.
   d. Approval for photochromatic tint shall be given when the member has a documented medical
condition that causes photosensitivity and less costly alternatives are inadequate.
   e. Approval for press-on prisms shall be granted for members whose vision cannot be adequately
corrected with other covered prisms.
   (Cross reference 78.28(3))

78.6(5) Noncovered services. Noncovered services include, but are not limited to, the following
services:
   a. Glasses with cosmetic gradient tint lenses or other eyewear for cosmetic purposes.
   b. Glasses for occupational eye safety.
   c. A second pair of glasses or spare glasses.
d. Cosmetic surgery and experimental medical and surgical procedures.
e. Sunglasses.
f. Progressive bifocal or trifocal lenses.

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

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

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

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

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

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

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

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

78.8(2) Indications and limitations of coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

78.9(1) Treatment plan. A plan of treatment shall be completed prior to the start of care and at a minimum reviewed every 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:

- Place of service.
- Type of service to be rendered and the treatment modalities being used.
- Frequency of the services.
- Assistance devices to be used.
- Date home health services were initiated.
- Progress of member in response to treatment.
- Medical supplies to be furnished.
- Member’s medical condition as reflected by the following information, if applicable:
  1. Dates of prior hospitalization.
  2. Dates of prior surgery.
  3. Date last seen by a physician.
  4. Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
  5. Prognosis.
  6. Functional limitations.
  8. Date of last episode of instability.
  9. Date of last episode of acute recurrence of illness or symptoms.
  10. Medications.
  - Discipline of the person providing the service.
  - Certification period (no more than 60 days).
  - Estimated date of discharge from the hospital or home health agency services, if applicable.

- Physician’s signature and date. The plan of care must be signed and dated by the physician
before the claim for service is submitted for reimbursement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

78.9(8) Medical social services. Rescinded IAB 3/29/17, effective 5/3/17.
78.9(9) Home health agency care for maternity patients and children. The intent of home health agency services for maternity patients and children shall be to provide services when the members are unable to receive the care outside of their home and require home health care due to a high-risk factor. Routine prenatal, postpartum, or child health care is a covered service in a physician’s office or clinic and, therefore, is not covered by Medicaid when provided by a home health agency.

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

b. The following list of potential high-risk factors may indicate a need for home health services to prenatal maternity patients:
   (1) Aged 16 or under.
   (2) First pregnancy for a woman aged 35 or over.
   (3) Previous history of prenatal complications such as fetal death, eclampsia, C-section delivery, psychosis, or diabetes.
   (4) Current prenatal problems such as hypertensive disorders of pregnancy, diabetes, cardiac disease, sickle cell anemia, low hemoglobin, mental illness, or drug or alcohol abuse.
   (5) Sociocultural or ethnic problems such as language barriers, lack of family support, insufficient dietary practices, history of child abuse or neglect, or single mother.
   (6) Preexisting disabilities such as sensory deficits, or mental or physical disabilities.
   (7) Second pregnancy in 12 months.
   (8) Death of a close family member or significant other within the previous year.

c. The following list of potential high-risk factors may indicate a need for home health services to postpartum maternity patients:
   (1) Aged 16 or under.
   (2) First pregnancy for a woman aged 35 or over.
   (3) Major postpartum complications such as severe hemorrhage, eclampsia, or C-section delivery.
   (4) Preexisting mental or physical disabilities such as deaf, blind, hemiplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or intellectual disability.
   (5) Drug or alcohol abuse.
   (6) Symptoms of postpartum psychosis.
   (7) Special sociocultural or ethnic problems such as lack of job, family problems, single mother, lack of support system, or history of child abuse or neglect.
   (8) Demonstrated disturbance in maternal and infant bonding.
   (9) Discharge or release from hospital against medical advice before 36 hours postpartum.
   (10) Insufficient antepartum care by history.
   (11) Multiple births.
   (12) Nonhospital delivery.

d. The following list of potential high-risk factors may indicate a need for home health services to infants:
   (1) Birth weight of five pounds or under or over ten pounds.
   (2) History of severe respiratory distress.
   (3) Major congenital anomalies such as neonatal complications which necessitate planning for long-term follow-up such as postsurgical care, poor prognosis, home stimulation activities, or periodic development evaluation.
   (4) Disabling birth injuries.
(5) Extended hospitalization and separation from other family members.
(6) Genetic disorders, such as Down’s syndrome, and phenylketonuria or other metabolic conditions that may lead to intellectual disability.
(7) Noted parental rejection or indifference toward baby such as never visiting or calling the hospital about the baby’s condition during the infant’s extended stay.
(8) Family sociocultural or ethnic problems such as low education level or lack of knowledge of child care.
(9) Discharge or release against medical advice before 36 hours of age.
(10) Nutrition or feeding problems.
   e. The following list of potential high-risk factors may indicate a need for home health services to preschool or school-age children:
      (1) Child or sibling victim of child abuse or neglect.
      (2) Intellectual disability or other physical disabilities necessitating long-term follow-up or major readjustments in family lifestyle.
      (3) Failure to complete the basic series of immunizations by 18 months, or boosters by 6 years.
      (4) Chronic illness such as asthma, cardiac, respiratory or renal disease, diabetes, cystic fibrosis, or muscular dystrophy.
      (5) Malignancies such as leukemia or carcinoma.
      (6) Severe injuries necessitating treatment or rehabilitation.
      (7) Disruption in family or peer relationships.
      (8) Suspected developmental delay.
      (9) Nutritional deficiencies.

78.9(10) Private duty nursing or personal care services for persons aged 20 and under. Payment for private duty nursing or personal care services for persons aged 20 and under shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.
   a. Definitions.
      (1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member’s physician to a member in the member’s place of residence or outside the member’s residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.
      Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child’s caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member. Enhanced payment under the interim fee schedule shall be made available for services to children who are technology dependent, i.e., ventilator dependent or whose medical condition is so unstable as to otherwise require intensive care in a hospital.
      Private duty nursing or personal care services do not include:
      1. Respite care, which is a temporary intermission or period of rest for the caregiver.
      2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
      3. Services provided to other persons in the member’s household.
      4. Services requiring prior authorization that are provided without regard to the prior authorization process.
      5. Transportation services.
      6. Homework assistance.
      (2) Personal care services are those services provided by a home health aide or certified nurse’s aide and which are delegated and supervised by a registered nurse under the direction of the member’s physician to a member in the member’s place of residence or outside the member’s residence, when normal life activities take the member outside the place of residence. Place of residence does not include
nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member’s plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child’s caregiver, in the development and implementation of the plan of treatment.

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

b. Requirements.

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

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

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

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

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

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

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09;  ARC 9315B, IAB 12/29/10, effective 2/2/11;  ARC 0065C, IAB 4/4/12, effective 6/1/12;  ARC 3085C, IAB 3/29/17, effective 5/3/17]

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

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

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

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

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

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

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

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

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

(1) Physical fitness equipment, e.g., an exercycle, weights.
(2) First-aid or precautionary-type equipment, e.g., preset portable oxygen units.
(3) Self-help devices, e.g., safety grab bars, raised toilet seats.
(4) Training equipment, e.g., speech teaching machines, braille training texts.
(5) Equipment used for environmental control or to enhance the environmental setting, e.g., room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners.

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

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

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

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

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

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

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

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

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

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

j. Reimbursement over the established fee schedule amount is allowed when prior authorization has been obtained. See 78.10(5)”n” for prior authorization requirements.
78.10(2) Durable medical equipment. DME is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

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

Exceptions:
1. Oxygen services in a nursing facility or an intermediate care facility for persons with an intellectual disability when all of the following requirements and conditions have been met:
   1. A Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile is completed by a physician, physician assistant, or advanced registered nurse practitioner and qualifies the member in accordance with Medicare criteria.
   2. Additional documentation shows that the member requires oxygen for 12 hours or more per day for at least 30 days.
   3. Oxygen logs must be maintained by the provider. The time between any reading shall not exceed more than 45 days. The documentation maintained in the provider record must contain the following:
      - The initial, periodic and ending reading on the time meter clock on each oxygen system, and
      - The dates of each initial, periodic and ending reading, and
      - Evidence of ongoing need for oxygen services.
   4. The maximum Medicaid payment shall be based on the least costly method of oxygen delivery.
   5. Oxygen prescribed “PRN” or “as necessary” is not payable.
   6. Medicaid payment shall be made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system and costs for servicing and repair of equipment are included in the Medicaid payment and shall not be separately payable.
   7. Payment is not allowed for oxygen services that are not documented according to the department of inspections and appeals requirements at 481—subrule 58.21(8).

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


b. The types of durable medical equipment covered through the Medicaid program include, but are not limited to:
   Automated medication dispenser. See 78.10(5)“d” for prior authorization requirements.
   Bathtub/shower chair, bench. See 78.10(5)“g” and “j” for prior authorization requirements.
   Commode, shower commode chair. See 78.10(5)“j” for prior authorization requirements.
   Decubitus equipment.
   Dialysis equipment.
   Diaphragm (contraceptive device).
   Enclosed bed. See 78.10(5)“a” for prior authorization requirements.
   Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.
   Heat/cold application device.
   Hospital bed and accessories.
   Inhalation equipment. See 78.10(5)“e” 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(4))
c. Cranial orthotic device. Payment shall be approved for cranial orthotic devices when the device is medically necessary for the postsurgical treatment of synostotic plagiocephaly. Payment shall also be approved when there is documentation supporting moderate to severe nonsynostotic positional plagiocephaly and either:
1. The member is 12 weeks of age but younger than 36 weeks of age and has failed to respond to a two-month trial of repositioning therapy; or
2. The member is 36 weeks of age but younger than 108 weeks of age and there is documentation of either of the following conditions:
   1. Cephalic index at least two standard deviations above the mean for the member’s gender and age; or
   2. Asymmetry of 12 millimeters or more in the cranial vault, skull base, or orbitotragial depth.

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

a. The types of medical supplies and supplies necessary for the effective use of a payable item covered through the Medicaid program include, but are not limited to:
   Active pharmaceutical ingredients and excipients identified as preferred on the preferred drug list published pursuant to Iowa Code section 249A.20A.
   Catheter (indwelling Foley).
   Colostomy and ileostomy appliances.
   Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape.
   Diabetic supplies (including but not limited to blood glucose test strips, lancing devices, lancets, needles, syringes, and diabetic urine test supplies). See 78.10(5) “e” for prior authorization requirements.
   Dialysis supplies.
   Disposable catheterization trays or sets (sterile).
   Disposable irrigation trays or sets (sterile).
   Disposable saline enemas (e.g., sodium phosphate type).
   Dressings.
   Elastic antiembolism support stocking.
   Enema.
   Hearing aid batteries.
   Incontinence products (for members three years of age and older).
   Oral nutritional products. See 78.10(5) “m” for prior authorization requirements.
   Ostomy appliances and supplies.
   Respirator supplies.
   Shoes, diabetic.
   Surgical supplies.
   Urinary collection supplies.

b. Only the following types of medical supplies will be approved for payment for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability when prescribed by the physician, physician assistant, or advanced registered nurse practitioner:
Catheter (indwelling Foley).
Diabetic supplies (including but not limited to lancing devices, lancets, needles and syringes, blood glucose test strips, and diabetic urine test supplies).
Disposable catheterization trays or sets (sterile).
Disposable irrigation trays or sets (sterile).
Disposable saline enemas (e.g., sodium phosphate type).
Ostomy appliances and supplies.
Shoes, diabetic.

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

a. Enclosed beds. Payment for an enclosed bed shall be approved when prescribed for a member who meets all of the following conditions:
   (1) The member has a diagnosis-related cognitive or communication impairment that results in risk to safety.
   (2) The member’s mobility puts the member at risk for injury.
   b. External insulin infusion pumps. Payment will be approved according to Medicare coverage criteria.
   c. Vest airway clearance systems. Payment will be approved for a vest airway clearance system when prescribed by a pulmonologist for a member with a diagnosis of a lung disorder if all of the following conditions are met:
      (1) Pulmonary function tests for the 12 months before the initiation of the vest demonstrate an overall significant decrease in lung function.
      (2) The member resides in an independent living situation or has a medical condition that precludes the caregiver from administering traditional chest physiotherapy.
      (3) Treatment by flutter device failed or is contraindicated.
      (4) Treatment by intrapulmonary percussive ventilation failed or is contraindicated.
      (5) All other less costly alternatives have been tried.
   d. Automated medication dispenser. Payment will be approved for an automated medication dispenser when prescribed for a member who meets all of the following conditions:
      (1) The member has a diagnosis indicative of cognitive impairment or age-related factors that affect the member’s ability to remember to take medications.
      (2) The member is on two or more medications prescribed to be administered more than one time per day.
      (3) The availability of a caregiver to administer the medications or perform setup is limited or nonexistent.
      (4) Less costly alternatives, such as medisets or telephone reminders, have failed.
   e. Diabetic equipment and supplies. If the department has a current agreement for a rebate with at least one manufacturer of a particular category of diabetic equipment or supplies (by healthcare common procedure coding system (HCPCS) code), prior authorization is required for any equipment or supplies in that category produced by a manufacturer that does not have a current agreement to provide a rebate to the department (other than supplies for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability). Prior approval shall be granted when the member’s medical condition necessitates use of equipment or supplies produced by a manufacturer that does not have a current rebate agreement with the department.
   f. Speech generating device. Payment shall be approved according to Medicare coverage criteria. Form 470-2145, Speech Generating Device System Selection, completed by a speech-language pathologist and a physician’s, physician assistant’s, or advanced registered nurse practitioner’s prescription for a particular device shall be submitted with the request for prior authorization. In addition, documentation from a speech-language pathologist must include information on the member’s educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations. A minimum one-month trial period is required for all devices. The Iowa Medicaid enterprise consultant with
expertise in speech-language pathology will evaluate each prior authorization request and make recommendations to the department.

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

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

i. Power wheelchair attendant control. Payment shall be approved when the member has a power wheelchair and:
   (1) Has a sip ’n puff attachment, or
   (2) The medical documentation demonstrates the member’s difficulty operating the wheelchair in tight space, or
   (3) The medical documentation demonstrates the member becomes fatigued.

j. Shower commode chairs. Prior authorization shall be granted when documentation from a physician, physician assistant, advanced registered nurse practitioner, physical therapist or occupational therapist indicates that the member:
   (1) Is unable to stand for the duration of a shower or is unable to get in or out of a bathtub, and
   (2) Needs upper body support while sitting, and
   (3) Needs to be tilted back for safety or pressure relief, if a tilt-in-space chair is requested.

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

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

m. Oral nutritional products. Payment shall be approved when the member is not able to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology, to the extent that supplementation is necessary to provide 51 percent or more of the daily caloric intake, or when the use of oral nutritional products is otherwise determined medically necessary in accordance with evidence-based guidelines for treatment of the member’s condition. Nutritional products consumed orally are not covered for members in nursing facilities or intermediate care facilities for persons with an intellectual disability.

n. Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved for bariatric equipment, pediatric equipment or other specialized medical equipment, supply, prosthetic or orthotic which:
   (1) Meets the definition of a code in the current healthcare common procedure coding system (HCPCS), and
   (2) Has an established Medicaid fee schedule amount that is inadequate to cover the provider’s cost to obtain the equipment or supply.

o. Customized wheelchairs, 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.

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 Iowa Plan provider for authorization of the services.
   a. Initial plan. The initial services implementation plan must meet all of the following criteria:
      (1) The plan conforms to the medical necessity requirements in subrule 78.12(6);
      (2) The plan is consistent with the written diagnosis and treatment recommendations made by the licensed practitioner of the healing arts;
      (3) The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;
      (4) The provider meets the requirements of rule 441—77.12(249A); and
      (5) The plan does not exceed six months’ duration.
   b. Subsequent plans. The Iowa Plan contractor may approve a subsequent services implementation plan according to the conditions in paragraph 78.12(5)“a” if the services are recommended by a licensed practitioner of the healing arts who has:
      (1) Reexamined the member;
      (2) Reviewed the original diagnosis and treatment plan; and
      (3) Evaluated the member’s progress, including a formal assessment as required by 78.12(4)”c”(3).

78.12(6) Medical necessity. Nothing in this rule shall be deemed to exempt coverage of behavioral health intervention from the requirement that services be medically necessary. For purposes of behavioral health intervention, “medically necessary” means that the service is:
   a. Consistent with the diagnosis and treatment of the member’s condition and specific to a daily impairment caused by a mental disorder;
   b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member’s caregiver;
   c. The least costly type of service that can reasonably meet the medical needs of the member; and
   d. In accordance with the standards of evidence-based medical practice. The standards of practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of practice identified by:
      (1) Knowledgeable Iowa clinicians practicing or teaching in the field; and
      (2) The professional literature regarding evidence-based practices in the field.

This rule is intended to implement Iowa Code section 249A.4 and 2010 Iowa Acts, chapter 1192, section 31.
[ARC 8504B, IAB 2/10/10, effective 3/22/10; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 1850C, IAB 2/4/15, effective 4/1/15; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

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.
   a. Reimbursement for costs of the member’s meals necessary during periods of transportation and medical treatment.
   b. Reimbursement of lodging expenses incurred by the member during periods of transportation and medical treatment.
   c. Reimbursement of car rental costs incurred by the member during periods of transportation and medical treatment.
   d. Reimbursement of a medically necessary escort’s travel expenses when an escort is required because of the member’s needs.

78.13(2) Exclusions. Nonemergency medical transportation is not available through the Iowa Medicaid program for:
   a. Transportation to obtain services not covered by Iowa Medicaid;
   b. Transportation to providers that are not enrolled in Iowa Medicaid;
   c. Transportation for members residing in nursing facilities or ICF/ID facilities when such facilities provide the transportation (i.e., within 30 miles, one way, of the facility);
   d. Transportation of family members to visit or participate in therapy when the member is hospitalized or institutionalized;
   e. Transportation to durable medical equipment providers when such providers offer a delivery service that can be accessed at no cost to the member, unless the equipment requires a fitting that cannot be provided without transporting the member;
   f. Reimbursement to HCBS and Medicaid providers for transportation provided as part of other covered services, such as personal care, home health, and supported community living services;
   g. Transportation to a pharmacy that provides a free delivery service, with the exception of new prescription fills that are otherwise not available to the patient in the absence of nonemergency medical transportation services; and
   h. Emergency transportation.

78.13(3) Conditions and limitations on covered services. Nonemergency medical transportation services are subject to the following limitations and conditions:
   a. Member request. When a member needs nonemergency transportation to receive medical care provided by the Iowa Medicaid program, the member must contact the broker with as much advance notice as possible, but not more than 30 days’ advance notice.
      (1) Generally, members who require a ride from a transportation provider scheduled by the broker must contact the broker at least two business days in advance of the member’s appointment to schedule the transportation. For purposes of calculating the two-business-day notice obligation, the advance notice includes the day of the medical appointment but not the day of the telephone call.
      (2) If the member’s nonemergency transportation need for a ride from a transportation provider scheduled by the broker makes the provision of two business days’ notice impossible because of the member’s urgent transportation need, the member must provide as much advance notice as is possible before the transportation need so that the broker can appropriately schedule the most economical form of transportation for the member. Urgent transportation needs for a ride from a transportation provider scheduled by the broker are limited to unscheduled episodic situations in which there is no immediate threat to life or limb but which require that the broker schedule transportation with less than two business days’ notice. Examples of urgent trips include, but are not limited to:
         1. Postsurgical or medical follow-up care specified by a health care provider;
         2. Unexpected preoperative appointments;
         3. Hospital discharges;
         4. Appointments for new medical conditions or tests; and
         5. Dialysis.
      (3) The two-business-day advance notice obligation does not apply when the member requests only mileage reimbursement. To be eligible for mileage reimbursement:
         1. The member must notify the broker no later than the day of the trip;
2. The transportation must be provided by a driver with a valid driver’s license and insurance coverage on the vehicle at the time of the transport; and
3. The other requirements of rule 441—78.13(249A) must be met.

b. No free transportation alternatives available. Member transportation through the nonemergency medical transportation broker is not available to the member when the member is capable of securing the member’s own transportation at no cost to the member (e.g., free-gas voucher programs).

c. No member transportation alternatives available. Members who have their own transportation available to them are required to use their own vehicle and seek mileage reimbursement. For purposes of determining whether or not the member has the member’s own transportation that is available to the member, the broker shall take into consideration:

(1) Whether the member owns a vehicle;
(2) Whether a member-owned vehicle is in working mechanical order and is licensed;
(3) Whether the member has a valid driver’s license and auto insurance;
(4) Whether the member is unable to drive because of age, physical condition, cognitive impairment, or developmental limitations; and
(5) Whether friends or family are available to transport the member to the member’s medical appointment and receive mileage reimbursement.

d. Limitations on reimbursement for meals. Reimbursement for costs of members’ meals necessary during periods of transportation and medical treatment is limited to situations in which:

(1) The transportation being provided spans the entire meal period;
(2) The one-way distance to or from the medical appointment is more than 50 miles;
(3) The meal is necessary to satisfy the needs of the member or medically necessary escort; and
(4) The meal reimbursement is limited to the subsistence allowance amounts applicable to state officers and state employees pursuant to Iowa Administrative Code rule 11—41.6(8A) and is supported by detailed receipts.

e. Limitations on reimbursement for lodging expenses. Reimbursement of lodging expenses incurred by members during periods of transportation and medical treatment is limited to reasonable reimbursement for expenses incurred by the member or the medically necessary escort, or both, during a nonemergency trip provided by the broker when the one-way distance to or from the medical appointment is more than 50 miles, supported by detailed receipts, and required for treatment.

f. Closest medical provider. Nonemergency medical transportation will only be provided to members to the closest qualified and enrolled Medicaid provider unless:

(1) The difference between the closest qualified and enrolled Medicaid provider and the enrolled provider requested by the member is less than 10 miles one way; or
(2) The additional cost of transportation to the enrolled provider requested by the member is medically justified based on:

1. The member’s previous relationship with the requested provider; or
2. The member’s prior experience with the requested provider; or
3. The requested provider’s special expertise or experience; or
4. A referral requiring the member to be seen by the requested provider.

g. Member scheduling obligations. Members who require a ride will need to schedule medical appointments on days the transportation provider sends a shuttle to facilitate the provision of the most economical nonemergency medical transportation available, subject to reasonable medical exceptions.

h. Abusive behavior. Members who are abusive or inappropriate may be restricted by the department to only receiving mileage reimbursement. Such restricted members will be responsible for finding their own way to their medical appointments.

i. Member claim submission. Members must submit claims and supporting documentation to the broker within 120 days of the date of service. The broker shall deny member claims submitted more than 120 days from the date of service.

78.13(4) Grievance procedure. The broker shall establish an internal grievance procedure for members and transportation providers.
a. Members may appeal to the department pursuant to 441—Chapter 7 as an “aggrieved person.”

b. Transportation providers.

(1) Consent for state fair hearing.

1. Transportation providers that are contracted with the broker and are in good standing with the broker may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member.

2. The transportation provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member’s lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the transportation provider submits a document providing such member approval with the request for a state fair hearing.

3. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider’s bringing the state fair hearing on the member’s behalf.

(2) For all transportation provider grievances not addressed by paragraph 78.13(4)“b,” the grievance process shall end with binding arbitration, with a designee of the Iowa Medicaid enterprise as arbitrator.

[ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8994B, IAB 8/11/10, effective 10/1/10; ARC 1264C, IAB 1/8/14, effective 3/1/14; ARC 1976C, IAB 4/29/15, effective 7/1/15]

441—78.14(249A) Hearing aids. Payment shall be approved for a hearing aid and examinations subject to the following conditions:

78.14(1) Physician examination. The member shall have an examination by a physician to determine that the member has no condition which would contraindicate the use of a hearing aid. This report shall be documented in the patient record. The requirement for a physician evaluation shall be waived for members 18 years of age or older when the member has signed an informed consent statement acknowledging that the member:

a. Has been advised that it may be in the member’s best health interest to receive a medical evaluation from a licensed physician before purchase of a hearing aid.

b. Does not wish to receive a medical evaluation prior to purchase of a hearing aid.

78.14(2) Audiological testings. A physician or an audiologist shall perform audiological testing as a part of making a determination that a member could benefit from the use of a hearing aid. The department shall cover vestibular testing performed by an audiologist only when prescribed by a physician.

78.14(3) Hearing aid evaluation. A physician or an audiologist shall perform a hearing aid evaluation to establish if a member could benefit from a hearing aid. When a hearing aid is recommended for a member, the physician or audiologist recommending the hearing aid shall see the member at least one time within 30 days after purchase of the hearing aid to determine that the aid is adequate.

78.14(4) Hearing aid selection. A physician or audiologist may recommend a specific brand or model appropriate to the member’s condition. When a physician or an audiologist makes a general hearing aid recommendation, a hearing aid dispenser may perform the tests to determine the specific brand or model appropriate to the member’s condition.

78.14(5) Travel. When a member is unable to travel to the physician or audiologist because of health reasons, the department shall make payment for travel to the member’s place of residence or other suitable location. The department shall make payment to physicians as specified in 78.1(8) and payment to audiologists at the same rate it reimburses state employees for travel.

78.14(6) Purchase of hearing aid. The department shall pay for the type of hearing aid recommended when purchased from an eligible licensed hearing aid dispenser pursuant to rule 441—77.13(249A). The department shall pay for binaural amplification when:

a. A child needs the aid for speech development,
b. The aid is needed for educational or vocational purposes,
c. The aid is for a blind member,
d. The member’s hearing loss has caused marked restriction of daily activities and constriction of interests resulting in seriously impaired ability to relate to other people, or
e. Lack of binaural amplification poses a hazard to a member’s safety.

78.14(7) Payment for hearing aids.

a. Payment for hearing aids shall be acquisition cost plus a dispensing fee covering the fitting and service for six months. The department shall make payment for routine service after the first six months. Dispensing fees and payment for routine service shall not exceed the fee schedule appropriate to the place of service. Shipping and handling charges are not allowed.

b. Payment for ear mold and batteries shall be at the current audiologist’s fee schedule.

c. Payment for repairs shall be made to the dealer for repairs made by the dealer. Payment for in-house repairs shall be made at the current fee schedule. Payment shall also be made to the dealer for repairs when the hearing aid is repaired by the manufacturer or manufacturer’s depot. Payment for out-of-house repairs shall be at the amount shown on the manufacturer’s invoice. Payment shall be allowed for a service or handling charge when it is necessary for repairs to be performed by the manufacturer or manufacturer’s depot and this charge is made to the general public.

d. Prior approval. When prior approval is required, Form 470-4767, Examiner Report of Need for a Hearing Aid, shall be submitted along with the forms required by 441—paragraph 79.8(1)“a.”

(1) Payment for the replacement of a hearing aid less than four years old shall require prior approval except when the member is under 21 years of age. The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the member’s hearing that would require a different hearing aid. (Cross reference 78.28(4)“a”)

(2) Payment for a hearing aid costing more than $650 shall require prior approval. The department shall approve payment for either of the following purposes (Cross reference 78.28(4)“b”):

1. Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/− 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

2. Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job, and an in-office comparison of an analog aid and a digital aid matched (+/− 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

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

[ARC 8008B, IAB 7/29/09, effective 8/1/09]

441—78.15(249A) Orthopedic shoes. Payment shall be approved only for depth or custom-molded orthopedic shoes, inserts, and modifications, subject to the following definitions and conditions.

78.15(1) Definitions.

“Custom-molded shoe” means a shoe that:

1. Has been constructed over a cast or model of the recipient’s foot;
2. Is made of leather or another suitable material of equal quality;
3. Has inserts that can be removed, altered, or replaced according to the recipient’s conditions and needs; and
4. Has some form of closure.

“Depth shoe” means a shoe that:

1. Has a full length, heel-to-toe filler that when removed provides a minimum of 3/16 inch of additional depth used to accommodate custom-molded or customized inserts;
2. Is made from leather or another suitable material of equal quality;
3. Has some form of closure; and
4. Is available in full and half sizes with a minimum of three widths, so that the sole is graded to the size and width of the upper portions of the shoe according to the American Standard last sizing schedule or its equivalent.

"Insert" means a foot mold or orthosis constructed of more than one layer of a material that:
1. Is soft enough and firm enough to take and hold an impression during use, and
2. Is molded to the recipient’s foot or is made over a model of the foot.

78.15(2) Prescription. The recipient shall present to the provider a written prescription by a physician, a podiatrist, a physician assistant, or an advanced registered nurse practitioner that includes all of the following:
1. The date.
2. The patient’s diagnosis.
3. The reason orthopedic shoes are needed.
4. The probable duration of need.
5. A specific description of any required modification of the shoes.

78.15(3) Diagnosis. The recipient shall have a diagnosis of an orthopedic, neuromuscular, vascular, or insensate foot condition, supported by applicable codes from the current version of the International Classification of Diseases (ICD). A diagnosis of flat feet is not covered.

a. A recipient with diabetes must meet the Medicare criteria for therapeutic depth and custom-molded shoes.
   b. Custom-molded shoes are covered only when the recipient has a foot deformity and the provider has documentation of all of the following:
      (1) The reasons the recipient cannot be fitted with a depth shoe.
      (2) Pain.
      (3) Tissue breakdown or a high probability of tissue breakdown.
      (4) Any limitation on walking.

78.15(4) Frequency. Only two pairs of orthopedic shoes are allowed per recipient in a 12-month period unless documentation of change in size or evidence of excessive wear is submitted. EXCEPTION: School-aged children under the age of 21 may obtain athletic shoes in addition to the two pairs of shoes in a 12-month period.

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

441—78.16(249A) Community mental health centers. Payment will be approved for all reasonable and necessary services provided by a psychiatrist on the staff of a community mental health center. Payment will be approved for services provided by a clinical psychologist, social worker or psychiatric nurse on the staff of the center, subject to the following conditions:

78.16(1) Payment to a community mental health center will be approved for reasonable and necessary services provided to members by a psychiatrist, psychologist, social worker or psychiatric nurse on the staff of the center under the following conditions:

a. Services must be rendered under the supervision of a board-eligible or board-certified psychiatrist. All services must be performed under the supervision of a board-eligible or board-certified psychiatrist subject to the conditions set forth in 78.16(1)“b” with the following exceptions:
   (1) Services by staff psychiatrists, or
   (2) Services rendered by psychologists meeting the requirements of the National Register of Health Service Providers in Psychology, or
   (3) Services provided by a staff member listed in this subrule performing the preliminary diagnostic evaluation of a member for voluntary admission to one of the state mental health institutes.

b. Supervisory process.
   (1) Each patient shall have an initial evaluation completed which shall include at least one personal evaluation interview with a mental health professional, as defined under Iowa Code section 228.1. If the evaluation interview results indicate a need for an interview with a board-eligible or board-certified...
psychiatrist, then such referral shall be made. This must be accomplished before submission of the first claim for services rendered to that patient.

(2) Ongoing review and assessment of patients’ treatment needs, treatment plans, and the appropriateness of services rendered shall be assured through the peer review process in effect for community mental health centers, as directed by 2002 Iowa Acts, chapter 1120, section 13.

(3) and (4) Rescinded IAB 2/5/03, effective 2/1/03.

78.16(2) The treatment plans for and services rendered to patients of the center shall be evaluated and revised as necessary and appropriate, consistent with the standards of the peer review process described in subparagraph 78.16(1)“b”(1).

78.16(3) The peer review process and related activities, as described under subparagraph 78.16(1)“b”(1), are not payable as separate services under the Medicaid program. The center shall maintain the results of and information related to the peer review process, and these records shall be subject to audit by the department of human services or department designees, as necessary and appropriate.

78.16(4) Clinical records of medical assistance patients shall be available to the carrier on request. All these records shall be held confidential.

78.16(5) At the time of application for participation in the program the center will be provided with a form on which to list its professional staff. The center shall report acquisitions or losses of professional staff to the carrier within ten days.

78.16(6) Payment to a community mental health center will be approved for day treatment services for persons aged 21 or over if the center is certified by the department for day treatment services, the services are provided on the premises of the community mental health center or satellite office of the community mental health center, and the services meet the standards outlined herein.

a. Community mental health centers providing day treatment services for persons aged 21 or over shall have available a written narrative providing the following day treatment information:

(1) Documented need for day treatment services for persons aged 21 and over in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 21 and over that meet the day treatment program guidelines noted in 78.16(6)“b.”

(3) Organization and staffing including how the day treatment program for persons aged 21 and over fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff’s relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Day treatment services for persons aged 21 and over shall be structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression, and preventing hospitalization.

(1) Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions and training in medication management.

(2) Services are structured with an emphasis on program variation according to individual need.

(3) Services are provided for a period of three to five hours per day, three or four times per week.

(4) 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).
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.

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.

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.

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.

da. Admission criteria. Admission criteria for day treatment services for persons aged 20 or under shall reflect the following clinical indicators:

1. The patient is at risk for exclusion from normative community activities or residence.
2. The patient exhibits psychiatric symptoms, disturbances of conduct, decompensating conditions affecting mental health, severe developmental delays, psychological symptoms, or chemical dependency issues sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.
3. Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate.
4. The patient’s principal caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the patient, to enable adequate control of the patient’s behavior, and must be involved in the patient’s treatment. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.
5. The patient has the capacity to benefit from the interventions provided.

e. Individual treatment plan. Each patient receiving day treatment services shall have a treatment plan prepared. A preliminary treatment plan should be formulated within 3 days of participation after admission, and replaced within 30 calendar days by a comprehensive, formalized plan utilizing the comprehensive assessment. This individual treatment plan should reflect the patient’s strengths and weaknesses and identify areas of therapeutic focus. The treatment goals which are general statements of consumer outcomes shall be related to identified strengths, weaknesses, and clinical needs
with time-limited, measurable objectives. Objectives shall be related to the goal and have specific anticipated outcomes. Methods that will be used to pursue the objectives shall be stated. The plan should be reviewed and revised as needed, but shall be reviewed at least every 30 calendar days. The treatment plan shall be developed or approved by a board-eligible or board-certified psychiatrist, a staff psychiatrist, physician, or a psychologist registered either on the “National Register of Health Service Providers in Psychology” or the “Iowa Register of Health Service Providers for Psychology.” Approval will be evidenced by a signature of the physician or health service provider.

f. Discharge criteria. Discharge criteria for the day treatment program for persons aged 20 or under shall incorporate at least the following indicators:

(1) In the case of patient improvement:
   1. The patient’s clinical condition has improved as shown by symptom relief, behavioral control, or indication of mastery of skills at the patient’s developmental level. Reduced interference with and increased responsibility with social, vocational, interpersonal, or educational goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.
   2. Treatment goals in the individualized treatment plan have been achieved.
   3. An aftercare plan has been developed that is appropriate to the patient’s needs and agreed to by the patient and family, custodian, or guardian.

(2) If the patient does not improve:
   1. The patient’s clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.
   2. Patient, family, or custodian noncompliance with treatment or with program rules exists.

   g. Coordination of services. Programming services shall be provided in accordance with the individual treatment plan developed by appropriate day treatment staff, in collaboration with the patient and appropriate caretaker figure (parent, guardian, or principal caretaker), and under the supervision of the program director, coordinator, or supervisor.

   The program for each patient will be coordinated by primary care staff of the community mental health center. A coordinated, consistent array of scheduled therapeutic services and activities shall comprise the day treatment program. These may include counseling or psychotherapy, theme groups, social skills development, behavior management, and other adjunctive therapies. At least 50 percent of scheduled therapeutic program hours exclusive of educational hours for each patient shall consist of active treatment that specifically addresses the targeted problems of the population served. Active treatment shall be defined as treatment in which the program staff assume significant responsibility and often intervene.

   Family, guardian, or principal caretaker shall be involved with the program through family therapy sessions or scheduled family components of the program. They will be encouraged to adopt an active role in treatment. Medicaid will not make separate payment for family therapy services. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

   Therapeutic activities will be scheduled according to the needs of the patients, both individually and as a group.

   Scheduled therapeutic activities, which may include other program components as described above, shall be provided at least 3 hours per week up to a maximum of 15 hours per week.

   h. Stable milieu. The program shall formally seek to provide a stable, consistent, and cohesive therapeutic milieu. In part this will be encouraged by scheduling attendance such that a stable core of patients exists as much as possible. The milieu will consider the developmental and social stage of the participants such that no patient will be significantly involved with other patients who are likely to contribute to retardation or deterioration of the patient’s social and emotional functioning. To help establish a sense of program identity, the array of therapeutic interventions shall be specifically identified as the day treatment program. Program planning meetings shall be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider shall state how milieu stability will be provided.
i. **Chronic mental illness.** Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(6).

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

441—78.17(249A) **Physical therapists.** Payment will be approved for the same services payable under Title XVIII of the Social Security Act (Medicare).

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

441—78.18(249A) **Screening centers.** Payment will be approved for health screening as defined in 441—subrule 84.1(1) for Medicaid members under 21 years of age.

78.18(1) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a screening center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.18(2) Payment will be approved for necessary laboratory service related to an element of screening when performed by the screening center and billed as a separate item.

78.18(3) Periodicity schedules for health, hearing, vision, and dental screenings.

a. Payment will be approved for health, vision, and hearing screenings as follows:
   (1) Six screenings in the first year of life.
   (2) Four screenings between the ages of 1 and 2.
   (3) One screening a year at ages 3, 4, 5, and 6.
   (4) One screening a year at ages 8, 10, 12, 14, 16, 18, and 20.

b. Payment for dental screenings will be approved in conjunction with the health screenings up to age 12 months. Screenings will be approved at ages 12 months and 24 months and thereafter at six-month intervals up to age 21.

c. Interperiodic screenings will be approved as medically necessary.

78.18(4) When it is established by the periodicity schedule in 78.18(3) that an individual is in need of screening the individual will receive a notice that screening is due.

78.18(5) When an individual is screened, a member of the screening center shall complete a medical history. The medical history shall become part of the individual’s medical record.

78.18(6) Rescinded IAB 12/3/08, effective 2/1/09.

78.18(7) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a screening center for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.18(8) Payment shall be made for dental services provided by a dental hygienist employed by or under contract with a screening center.

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

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

441—78.19(249A) **Rehabilitation agencies.**

78.19(1) **Coverage of services.**

a. **General provisions regarding coverage of services.**
   (1) Services are provided in the member’s home or in a care facility (other than a hospital) by a speech therapist, physical therapist, or occupational therapist employed by or contracted by the agency. Services provided to a member residing in a residential care facility are payable when the facility submits a signed statement that the facility does not have these services available. The statement need only be submitted at the start of care unless the situation changes. Payment will not be made to a rehabilitation agency for therapy provided to a member residing in a nursing facility or an intermediate care facility for persons with an intellectual disability since these facilities are responsible for providing or paying for services required by members.
(2) All services must be determined to be medically necessary, reasonable, and meet a significant need of the recipient that cannot be met by a family member, friend, medical staff personnel, or other caregiver; must meet accepted standards of medical practice; and must be a specific and effective treatment for a patient’s medical or disabling condition.

(3) In order for a service to be payable, a licensed therapist must complete a plan of treatment every 30 days and indicate the type of service required. The plan of treatment must contain the information noted in subrule 78.19(2).

(4) There is no specific limitation on the number of visits for which payment through the program will be made so long as that amount of service is medically necessary in the individual case, is related to a diagnosed medical impairment or disabling condition, and meets the current standards of practice in each related field. Documentation must be submitted with each claim to support the need for the number of services being provided.

(5) Payments will be made both for restorative service and also for maintenance types of service. Essentially, maintenance services means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This would include persons with long-term illnesses or a disabling condition whose status is stable rather than posthospital. Refer to 78.19(1)"b"(7) and (8) for guidelines under restorative and maintenance therapy.

(6) Restorative or maintenance therapy sessions must meet the following criteria:
1. There must be face-to-face patient contact interaction.
2. Services must be provided primarily on an individual basis. Group therapy is covered, but total units of service in a month shall not exceed total units of individual therapy. Family members receiving therapy may be included as part of a group.
3. Treatment sessions may be no less than 15 minutes of service and no more than 60 minutes of service per date unless more than 60 minutes of service is required for a treatment session due to the patient’s specific condition. If more than 60 minutes of service is required for a treatment session, additional documentation of the specific condition and the need for the longer treatment session shall be submitted with the claim. A unit of treatment shall be considered to be 15 minutes in length.
4. Progress must be documented in measurable statistics in the progress notes in order for services to be reimbursed. Refer to 78.19(1)"b"(7) and (8) for guidelines under restorative and maintenance therapy.

(7) Payment will be made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a patient’s rehabilitation potential and establish appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic or trial therapy. Refer to 78.19(1)"b"(16) for guidelines under diagnostic or trial therapy.

b. Physical therapy services.

(1) To be covered under rehabilitation agency services, physical therapy services must relate directly and specifically to an active written treatment plan, follow a treatment plan established by the licensed therapist after consultation with the physician, be reasonable and necessary to the treatment of the person’s illness, injury, or disabling condition, be specific and effective treatment for the patient’s medical or disabling condition, and be of such a level of complexity and sophistication, or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

(2) A qualified physical therapist assistant may provide any restorative services performed by a licensed physical therapist under supervision of the therapist as set forth in the department of public health, professional licensure division, 645—subrule 200.20(7).

(3) The initial physical therapy evaluation must be provided by a licensed physical therapist.

(4) There must be an expectation that there will be a significant, practical improvement in the patient’s condition in a reasonable amount of time based on the patient’s restorative potential assessed by the physician.

(5) It must be demonstrated there is a need to establish a safe and effective maintenance program related to a specific disease state, illness, injury, or disabling condition.
(6) The amount, frequency, and duration of the services must be reasonable.

(7) Restorative therapy must be reasonable and necessary to the treatment of the patient’s injury or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment. There must be an expectation that the patient’s medical or disabling condition will show functional improvement in a reasonable period of time. Functional improvement means that demonstrable measurable increases have occurred in the patient’s level of independence outside the therapeutic environment.

(8) Generally, maintenance therapy means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes persons with long-term illnesses or disabling conditions whose status is stable rather than posthospital. Maintenance therapy is also appropriate for individuals whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels.

Where a maintenance program is appropriate, the initial evaluation and the instruction of the patient, family members, home health aides, facility personnel, or other caregivers to carry out the program are considered a covered physical therapy service. Payment shall be made for a maximum of three visits to establish a maintenance program and instruct the caregivers. Payment for supervisory visits to monitor the program is limited to two per month for a maximum period of 12 months. The plan of treatment must specify the anticipated monitoring activity of the supervisor.

Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

After 12 months of maintenance therapy, a reevaluation is a covered service, if medically necessary. A reevaluation will be considered medically necessary only if there is a significant change in residential or employment situation or the patient exhibits an increase or decrease in functional ability or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated restorative therapy. A statement by the interdisciplinary team of a person with developmental disabilities recommending a reevaluation and stating the basis for medical necessity will be considered as supporting the necessity of a reevaluation and may expedite approval.

(Restorative and maintenance therapy definitions also apply to speech and occupational therapy.)

When a patient is under a restorative physical therapy program, the patient’s condition is regularly reevaluated and the program adjusted by the physical therapist. It is expected that prior to discharge, a maintenance program has been designed by the physical therapist. Consequently, where a maintenance program is not established until after the restorative program has been completed, it would not be considered reasonable and necessary to the treatment of the patient’s condition and would be excluded from coverage.

(9) Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. These are covered when the patient’s condition is complicated by other conditions such as a circulatory deficiency or open wounds or if the service is an integral part of a skilled physical therapy procedure.

(10) Gait training and gait evaluation and training constitute a covered service if the patient’s ability to walk has been impaired by a neurological, muscular or skeletal condition or illness. The gait training must be expected to significantly improve the patient’s ability to walk or level of independence.

Repetitious exercise to increase endurance of weak or unstable patients can be safely provided by supportive personnel, e.g., aides, nursing personnel. Therefore, it is not a covered physical therapy service.

(11) Ultrasound, shortwave, and microwave diathermy treatments are considered covered services.

(12) Range of motion tests must be performed by a qualified physical therapist. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease or disabling condition which has resulted in a loss or restriction of mobility.

Documentation must reflect the degree of motion lost, the normal range of motion, and the degree to be restored.

Range of motion to unaffected joints only does not constitute a covered physical therapy service.
(13) Reconditioning programs after surgery or prolonged hospitalization are not covered as physical therapy.

(14) Therapeutic exercises would constitute a physical therapy service due either to the type of exercise employed or to the condition of the patient.

(15) Use of isokinetic or isotonic type equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament or tendon injury or postsurgical trauma. Billing can only be made for the time actually spent by the therapist in instructing the patient and assessing the patient’s progress.

(16) When recipients do not meet restorative or maintenance therapy criteria, diagnostic or trial therapy may be utilized. When the initial evaluation is not sufficient to determine whether there are rehabilitative goals that should be addressed, diagnostic or trial therapy to establish goals shall be considered appropriate. Diagnostic or trial therapy may be appropriate for recipients who need evaluation in multiple environments in order to adequately determine their rehabilitative potential. Diagnostic or trial therapy consideration may be appropriate when there is a need to assess the patient’s response to treatment in the recipient’s environment.

When during diagnostic or trial therapy a recipient has been sufficiently evaluated to determine potential for restorative or maintenance therapy, or lack of therapy potential, diagnostic or trial therapy ends. When as a result of diagnostic or trial therapy, restorative or maintenance therapy is found appropriate, claims shall be submitted noting restorative or maintenance therapy (instead of diagnostic or trial therapy).

At the end of diagnostic or trial therapy, the rehabilitation provider shall recommend continuance of services under restorative therapy, recommend continuance of services under maintenance therapy, or recommend discontinuance of services. Continuance of services under restorative or maintenance therapy will be reviewed based on the criteria in place for restorative or maintenance therapy.

Trial therapy shall not be granted more often than once per year for the same issue. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. Requests for subsequent diagnostic or trial therapy for the same issue would require documentation reflecting a significant change. See number 4 below for guidelines under a significant change. Further diagnostic or trial therapy for the same issue would not be considered appropriate when progress was not achieved, unless the reasons which blocked change previously are listed and the reasons the new diagnostic or trial therapy would not have these blocks are provided.

The number of diagnostic or trial therapy hours authorized in the initial treatment period shall not exceed 12 hours per month. Documentation of the medical necessity and the plan for services under diagnostic trial therapy are required as they will be reviewed in the determination of the medical necessity of the number of hours of service provided.

Diagnostic or trial therapy standards also apply to speech and occupational therapy.

The following criteria additionally must be met:
1. There must be face-to-face interaction with a licensed therapist. (An aide’s services will not be payable.)
2. Services must be provided on an individual basis. (Group diagnostic or trial therapy will not be payable.)
3. Documentation of the diagnostic therapy or trial therapy must reflect the provider’s plan for therapy and the recipient’s response.
4. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. A significant change would be considered as having occurred when any of the following exist: new onset, new problem, new need, new growth issue, a change in vocational or residential setting that requires a reevaluation of potential, or surgical intervention that may have caused new rehabilitative potentials.
5. For persons who received previous rehabilitative treatment, consideration of trial therapy generally should occur only if the person has incorporated any regimen recommended during prior treatment into the person’s daily life to the extent of the person’s abilities.
6. Documentation should include any previous attempts to resolve problems using nontherapy personnel (i.e., residential group home staff, family members, etc.) and whether follow-up programs from previous therapy have been carried out.

7. Referrals from residential, vocational or other rehabilitation personnel that do not meet present evaluation, restorative or maintenance criteria shall be considered for trial therapy. Documentation of the proposed service, the medical necessity and the current medical or disabling condition, including any secondary rehabilitative diagnosis, will need to be submitted with the claim.

8. Claims for diagnostic or trial therapy shall reflect the progress being made toward the initial diagnostic or trial therapy plan.

c. **Occupational therapy services.**

(1) To be covered under rehabilitation agency services, occupational therapy services must be included in a plan of treatment, improve or restore practical functions which have been impaired by illness, injury, or disabling condition, or enhance the person’s ability to perform those tasks required for independent functioning, be prescribed by a physician under a plan of treatment, be performed by a qualified licensed occupational therapist or a qualified licensed occupational therapist assistant under the general supervision of a qualified licensed occupational therapist as set forth in the department of public health, professional licensure division, rule 645—201.9(148B), and be reasonable and necessary for the treatment of the person’s illness, injury, or disabling condition.

(2) Restorative therapy is covered when an expectation exists that the therapy will result in a significant practical improvement in the person’s condition.

However, in these cases where there is a valid expectation of improvement met at the time the occupational therapy program is instituted, but the expectation goal is not realized, services would only be covered up to the time one would reasonably conclude the patient would not improve.

The guidelines under restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1)“b”(7), (8), and (16) apply to occupational therapy.

(3) Maintenance therapy, or any activity or exercise program required to maintain a function at the restored level, is not a covered service. However, designing a maintenance program in accordance with the requirements of 78.19(1)“b”(8) and monitoring the progress would be covered.

(4) The selection and teaching of tasks designed to restore physical function are covered.

(5) Planning and implementing therapeutic tasks, such as activities to restore sensory-integrative functions are covered. Other examples include providing motor and tactile activities to increase input and improve responses for a stroke patient.

(6) The teaching of activities of daily living and energy conservation to improve the level of independence of a patient which require the skill of a licensed therapist and meet the definition of restorative therapy is covered.

(7) The designing, fabricating, and fitting of orthotic and self-help devices are considered covered services if they relate to the patient’s condition and require occupational therapy. A maximum of 13 visits is reimbursable.

(8) Vocational and prevocational assessment and training are not payable by Medicaid. These include services which are related solely to specific employment opportunities, work skills, or work settings.

d. **Speech therapy services.**

(1) To be covered by Medicaid as rehabilitation agency services, speech therapy services must be included in a plan of treatment established by the licensed, skilled therapist after consultation with the physician, relate to a specific medical diagnosis which will significantly improve a patient’s practical, functional level in a reasonable and predictable time period, and require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable.

(2) Speech therapy activities which are considered covered services include: restorative therapy services to restore functions affected by illness, injury, or disabling condition resulting in a communication impairment or to develop functions where deficiencies currently exist. Communication impairments fall into the general categories of disorders of voice, fluency, articulation, language, and
swallowing disorders resulting from any condition other than mental impairment. Treatment of these conditions is payable if restorative criteria are met.

(3) Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to patients who have suffered a hearing loss (input impairment), constitutes a covered service if reasonable and necessary to the patient’s illness or injury. Group treatment is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

(4) Teaching a patient to use sign language and to use an augmentative communication device is reimbursable. The patient must show significant progress outside the therapy sessions in order for these services to be reimbursable.

(5) Where a maintenance program is appropriate, the initial evaluation, the instruction of the patient and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable. However, designing a maintenance program in accordance with the requirements of maintenance therapy and monitoring the progress are covered.

(6) The guidelines and limits on restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1) "b"(7), (8), and (16) apply to speech therapy. If the only goal of prior rehabilitative speech therapy was to learn the prerequisite speech components, then number “5” under 78.19(1) “b”(16) will not apply to trial therapy.

78.19(2) General guidelines for plans of treatment.

a. The minimum information to be included on medical information forms and treatment plans includes:

(1) The patient’s current medical condition and functional abilities, including any disabling condition.
(2) The physician’s signature and date (within the certification period).
(3) Certification period.
(4) Patient’s progress in measurable statistics. (Refer to 78.19(1) “b”(16).)
(5) The place services are rendered.
(6) Dates of prior hospitalization (if applicable or known).
(7) Dates of prior surgery (if applicable or known).
(8) The date the patient was last seen by the physician (if available).
(9) A diagnosis relevant to the medical necessity for treatment.
(10) Dates of onset of any diagnoses for which treatment is being rendered (if applicable).
(11) A brief summary of the initial evaluation or baseline.
(12) The patient’s prognosis.
(13) The services to be rendered.
(14) The frequency of the services and discipline of the person providing the service.
(15) The anticipated duration of the services and the estimated date of discharge (if applicable).
(16) Assistive devices to be used.
(17) Functional limitations.
(18) The patient’s rehabilitative potential and the extent to which the patient has been able to apply the skills learned in the rehabilitation setting to everyday living outside the therapy sessions.
(19) The date of the last episode of instability or the date of the last episode of acute recurrence of illness or symptoms (if applicable).
(20) Quantitative, measurable, short-term and long-term functional goals.
(21) The period of time of a session.
(22) Prior treatment (history related to current diagnosis) if available or known.

b. The information to be included when developing plans for teaching, training, and counseling include:

(1) To whom the services were provided (patient, family member, etc.).
(2) Prior teaching, training, or counseling provided.
(3) The medical necessity of the rendered services.
(4) The identification of specific services and goals.
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.

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.

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, group sessions or marathons, or psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

78.24(4) Rescinded IAB 10/12/94, effective 12/1/94.

78.24(5) The following services shall require review by a consultant to the department.

a. Protracted therapy beyond 16 visits. These cases shall be reviewed following the sixteenth therapy session and periodically thereafter.

b. Any service which does not appear necessary or appears to fall outside the scope of what is professionally appropriate or necessary for a particular condition.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

441—78.25(249A) Maternal health centers. Payment will be made for prenatal and postpartum medical care, health education, and transportation to receive prenatal and postpartum services. Payment
will be made for enhanced perinatal services for persons determined high risk. These services include additional health education services, nutrition counseling, social services, and one postpartum home visit. Maternal health centers shall provide trimester and postpartum reports to the referring physician. Risk assessment using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member’s pregnancy. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.25(1) Provider qualifications.
   a. Prenatal and postpartum medical services shall be provided by a physician, a physician assistant, or a nurse practitioner employed by or on contract with the center. Medical services performed by maternal health centers shall be performed under the supervision of a physician. Nurse practitioners and physician assistants performing under the supervision of a physician must do so within the scope of practice of that profession, as defined by Iowa Code chapters 152 and 148C, respectively.
   b. Rescinded IAB 12/3/08, effective 2/1/09.
   c. Education services and postpartum home visits shall be provided by a registered nurse.
   d. Nutrition services shall be provided by a licensed dietitian.
   e. Psychosocial services shall be provided by a person with at least a bachelor’s degree in social work, counseling, sociology, psychology, family and community services, health or human development, health education, or individual and family studies.

78.25(2) Services covered for all pregnant women. Services provided may include:
   a. Prenatal and postpartum medical care.
   b. Health education, which shall include:
      (1) Importance of continued prenatal care.
      (2) Normal changes of pregnancy including both maternal changes and fetal changes.
      (3) Self-care during pregnancy.
      (4) Comfort measures during pregnancy.
      (5) Danger signs during pregnancy.
      (6) Labor and delivery including the normal process of labor, signs of labor, coping skills, danger signs, and management of labor.
      (7) Preparation for baby including feeding, equipment, and clothing.
      (8) Education on the use of over-the-counter drugs.
      (9) Education about HIV protection.
   c. Home visit.
   d. Transportation to receive prenatal and postpartum services that is not payable under rule 441—78.11(249A) or 441—78.13(249A).
   e. Dental hygiene services within the scope of practice as defined by the dental board at 650—paragraph 10.5(3)”b.”

78.25(3) Enhanced services covered for women with high-risk pregnancies. Enhanced perinatal services may be provided to a patient who has been determined to have a high-risk pregnancy as documented by Form 470-2942, Medicaid Prenatal Risk Assessment. An appropriately trained physician or advanced registered nurse practitioner must be involved in staffing the patients receiving enhanced services.

Enhanced services are as follows:
   a. Rescinded IAB 12/3/08, effective 2/1/09.
   b. Education, which shall include as appropriate education about the following:
      (1) High-risk medical conditions.
      (2) High-risk sexual behavior.
      (3) Smoking cessation.
      (4) Alcohol usage education.
      (5) Drug usage education.
      (6) Environmental and occupational hazards.
c. Nutrition assessment and counseling, which shall include:
   (1) Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information.
   (2) Ongoing nutritional assessment.
   (3) Development of an individualized nutritional care plan.
   (4) Referral to food assistance programs if indicated.
   (5) Nutritional intervention.

d. Psychosocial assessment and counseling, which shall include:
   (1) A psychosocial assessment including: needs assessment, profile of client demographic factors, mental and physical health history and concerns, adjustment to pregnancy and future parenting, and environmental needs.
   (2) A profile of the client’s family composition, patterns of functioning and support systems.
   (3) An assessment-based plan of care, risk tracking, counseling and anticipatory guidance as appropriate, and referral and follow-up services.

e. A postpartum home visit within two weeks of the child’s discharge from the hospital, which shall include:
   (1) Assessment of mother’s health status.
   (2) Physical and emotional changes postpartum.
   (3) Family planning.
   (4) Parenting skills.
   (5) Assessment of infant health.
   (6) Infant care.
   (7) Grief support for unhealthy outcome.
   (8) Parenting of a preterm infant.
   (9) Identification of and referral to community resources as needed.

78.25(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a maternal health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

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

441—78.26(249A) Ambulatory surgical center services. Ambulatory surgical center services are those services furnished by an ambulatory surgical center in connection with a covered surgical procedure or a covered dental procedure. Covered procedures are listed in the fee schedule published on the department’s website.

78.26(1) Covered surgical procedures shall be those medically necessary procedures that are eligible for payment as physicians’ services, under the circumstances specified in rule 441—78.1(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(2) Covered dental procedures are those medically necessary procedures that are eligible for payment as dentists’ services, under the circumstances specified in rule 441—78.4(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting for Medicaid members whose mental, physical, or emotional condition necessitates deep sedation or general anesthesia.

78.26(3) The covered services provided by the ambulatory surgical center in connection with a Medicaid-covered surgical or dental procedure shall be those nonsurgical and nondental services that:
   a. Are medically necessary in connection with a Medicaid-covered surgical or dental procedure;
   b. Are eligible for payment as physicians’ services under the circumstances specified in rule 441—78.1(249A) or as dentists’ services under the circumstances specified in rule 441—78.4(249A); and
   c. Can safely and economically be performed in an outpatient setting, as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(4) Limits on covered services.
a. Abortion procedures are covered only when criteria in subrule 78.1(17) are met.
b. Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.
c. Preprocedure review by the IME medical services unit is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from the IME medical services unit. (Cross reference 78.28(6))

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]

441—78.27(249A) Home- and community-based habilitation services. Payment for habilitation services will only be made to providers enrolled to provide habilitation through the Iowa Medicaid enterprise. Effective March 17, 2022, payment shall only be made for services provided to members in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.27(1) Definitions.

“Adult” means a person who is 18 years of age or older.

“Assessment” means the review of the current functioning of the member using the service in regard to the member’s situation, needs, strengths, abilities, desires, and goals.

“Benefits education” means providing basic information to understand and access appropriate resources to pursue employment, and knowledge of work incentives and the Medicaid for employed persons with disabilities (MEPD) program. Benefits education may include gathering information needed to pursue work incentives and offering basic financial management information to members, families, guardians and legal representatives.

“Care coordinator” means the professional who assists members in care coordination as described in paragraph 78.53(1)“b.”

“Career exploration,” also referred to as “career planning,” means a person-centered, comprehensive employment planning and support service that provides assistance for waiver program participants to obtain, maintain or advance in competitive employment or self-employment. Career exploration is a focused, time-limited service engaging a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state’s minimum wage. The outcome of this service is documentation of the participant’s stated career objective and a career plan used to guide individual employment support.

“Career plan” means a written plan documenting the member’s stated career objective and used to guide individual employment support services for achieving competitive, integrated employment at or above the state’s minimum wage.

“Case management” means case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90.

“Comprehensive service plan” means an individualized, person-centered, and goal-oriented plan of services written in language understandable by the member using the service and developed collaboratively by the member and the case manager.

“Customized employment” means an approach to supported employment which individualizes the employment relationship between employees and employers in ways that meet the needs of both. Customized employment is based on an individualized determination of the strengths, needs, and interests of the person with a disability and is also designed to meet the specific needs of the employer. Customized employment may include employment developed through job carving, self-employment or entrepreneurial initiatives, or other job development or restructuring strategies that result in job responsibilities being customized and individually negotiated to fit the needs of the individual with a disability. Customized employment assumes the provision of reasonable accommodations and supports necessary for the individual to perform the functions of a job that is individually negotiated and developed.

“Department” means the Iowa department of human services.
“Emergency” means a situation for which no approved individual program plan exists that, if not addressed, may result in injury or harm to the member or to other persons or in significant amounts of property damage.

“HCBS” means home- and community-based services.

“Individual employment” means employment in the general workforce where the member interacts with the general public to the same degree as nondisabled persons in the same job, and for which the member is paid at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by persons without disabilities.

“Individual placement and support” means an evidence-based supported employment model that helps people with mental illness to seek and obtain employment.

“Integrated community employment” means work (including self-employment) for which an individual with a disability is paid at or above minimum wage and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by employees who are not disabled, where the individual interacts with other persons who are not disabled to the same extent as others who are in comparable positions, and which presents opportunities for advancement that are similar to those for employees who are not disabled. In the case of an individual who is self-employed, the business results in an income that is comparable to the income received by others who are not disabled and are self-employed in similar occupations.

“Integrated health home” means the provision of services to enrolled members as described in subrule 78.53(1).

“Interdisciplinary team” means a group of persons with varied professional backgrounds who meet with the member to develop a comprehensive service plan to address the member’s need for services.

“ISIS” means the department’s individualized services information system.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Member” means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals for qualifying members.

“Supported employment” means the ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state’s minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals. Supported employment services can be provided through many different service models.

“Supported self-employment” includes services and supports that assist the participant in achieving self-employment through the operation of a business; however, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. Assistance for self-employment may include aid to the individual in identifying potential business opportunities; assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business; identification of the supports necessary for the individual to operate the business; and ongoing assistance, counseling and guidance once the business has been launched.

“Sustained employment” means an individual employment situation that the member maintains over time but not for less than 90 calendar days following the receipt of employment services and supports.

78.27(2) Member eligibility. To be eligible to receive home- and community-based habilitation services, a member shall meet the following criteria:

a. Risk factors. The member has at least one of the following risk factors:
(1) The member has undergone or is currently undergoing psychiatric treatment more intensive
than outpatient care (e.g., emergency services, alternative home care, partial hospitalization, or inpatient
hospitalization) more than once in the member’s life; or
(2) The member has a history of psychiatric illness resulting in at least one episode of continuous,
professional supportive care other than hospitalization.
   b. Need for assistance. The member has a need for assistance demonstrated by meeting at least
two of the following criteria on a continuing or intermittent basis for at least two years:
   (1) The member is unemployed, is employed in a sheltered setting, or has markedly limited skills
and a poor work history.
   (2) The member requires financial assistance for out-of-hospital maintenance and is unable to
procure this assistance without help.
   (3) The member shows severe inability to establish or maintain a personal social support system.
   (4) The member requires help in basic living skills such as self-care, money management,
housekeeping, cooking, and medication management.
   (5) The member exhibits inappropriate social behavior that results in a demand for intervention.
   c. Income. The countable income used in determining the member’s Medicaid eligibility does not
exceed 150 percent of the federal poverty level.
   d. Needs assessment. The interRAI - Child and Youth Mental Health (ChYMH) for youth
aged 16 to 18 or the interRAI - Community Mental Health (CMH) for those aged 19 and older has
been completed, and based on information submitted on the information submission tool and other
supporting documentation as relevant, the IME medical services unit has determined that the member is
in need of home- and community-based habilitation services. The interRAI - Child and Youth Mental
Health (ChYMH) and the interRAI - Community Mental Health (CMH) information submission tools
are available on request from the IME medical services unit. Copies of the information submission tool
for an individual are available to that individual from the individual’s case manager, integrated health
home care coordinator, or managed care organization. The designated case manager or integrated health
home care coordinator shall:
   (1) Arrange for the completion of the interRAI, before services begin and annually thereafter.
   (2) Use the information submission tool and other supporting documentation as relevant to
develop a comprehensive service plan as specified in subrule 78.27(4), before services begin and
annually thereafter.
   e. Plan for service. The department has approved the member’s comprehensive service plan for
home- and community-based habilitation services. Home- and community-based habilitation services
included in a comprehensive service plan or treatment plan that has been validated through ISIS shall
be considered approved by the department. Home- and community-based habilitation services provided
before approval of a member’s eligibility for the program cannot be reimbursed.
   (1) The member’s comprehensive service plan shall be completed annually according to the
requirements of subrule 78.27(4). A service plan may change at any time due to a significant change in
the member’s needs.
   (2) The member’s habilitation services shall not exceed the maximum number of units established
for each service in 441—subrule 79.1(2).
   (3) The cost of the habilitation services shall not exceed unit expense maximums established in
441—subrule 79.1(2).

78.27(3) Application for services. The member, case manager or integrated health home care
coordinator shall apply for habilitation services on behalf of a member by contacting the IME medical
services unit. The department shall issue a notice of decision to the applicant when financial eligibility
and needs-based eligibility determinations have been completed.

78.27(4) Comprehensive service plan. Individualized, planned, and appropriate services shall be
guided by a member-specific comprehensive service plan or treatment plan developed with the member
in collaboration with an interdisciplinary team, as appropriate. Medically necessary services shall be
planned for and provided at the locations where the member lives, learns, works, and socializes.
a. Development. A comprehensive service plan or treatment plan shall be developed for each member receiving home- and community-based habilitation services based on the member’s current assessment and shall be reviewed on an annual basis.

(1) The case manager or the integrated health home care coordinator shall establish an interdisciplinary team as selected by the member or the member’s legal representative. The team shall include the case manager or integrated health home care coordinator and the member and, if applicable, the member’s legal representative, the member’s family, the member’s service providers, and others directly involved with the member.

(2) With assistance from the member and the interdisciplinary team, the case manager or integrated health home care coordinator shall identify the member’s services based on the member’s needs, the availability of services, and the member’s choice of services and providers.

(3) The comprehensive service plan development shall be completed at the member’s home or at another location chosen by the member.

(4) The interdisciplinary team meeting shall be conducted before the current comprehensive service plan expires.

(5) The comprehensive service plan shall reflect desired individual outcomes.

(6) Services defined in the comprehensive service plan shall be appropriate to the severity of the member’s problems and to the member’s specific needs or disabilities.

(7) Activities identified in the comprehensive service plan shall encourage the ability and right of the member to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process.

(8) For members receiving home-based habilitation in a licensed residential care facility of 16 or fewer beds, the service plan shall address the member’s opportunities for independence and community integration.

(9) The initial comprehensive service plan or treatment plan and annual updates to the comprehensive service plan or treatment plan must be approved by the IME medical services unit in ISIS before services are implemented. Services provided before the approval date are not payable. The written comprehensive service plan or treatment plan must be completed, signed and dated by the case manager or integrated health home care coordinator within 30 calendar days after plan approval.

(10) Any changes to the comprehensive service plan or treatment plan must be approved by the IME medical services unit for members not eligible to enroll in a managed care organization in ISIS before the implementation of services. Services provided before the approval date are not payable.

b. Service goals and activities. The comprehensive service plan shall:

(1) Identify observable or measurable individual goals.

(2) Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.

(3) Identify the staff persons, businesses, or organizations responsible for carrying out the interventions or supports.

(4) List all Medicaid and non-Medicaid services received by the member and identify:

1. The name of the provider responsible for delivering the service;
2. The funding source for the service; and
3. The number of units of service to be received by the member.

(5) Identify for a member receiving home-based habilitation:

1. The member’s living environment at the time of enrollment;
2. The number of hours per day of on-site staff supervision needed by the member; and
3. The number of other members who will live with the member in the living unit.

(6) Include a separate, individualized, anticipated discharge plan that is specific to each service the member receives.

c. Rights restrictions. Any rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The comprehensive service plan or treatment plan shall include documentation of:
(1) Any restrictions on the member’s rights, including maintenance of personal funds and self-administration of medications;
(2) The need for the restriction; and
(3) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

d. Emergency plan. The comprehensive service plan or treatment plan shall include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall be developed as follows:
(1) The member’s interdisciplinary team shall identify in the comprehensive service plan or treatment plan any health and safety issues applicable to the individual member based on information gathered before the team meeting, including a risk assessment.
(2) The interdisciplinary team shall identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member’s needs change.
(3) Providers of applicable services shall provide for emergency backup staff.

e. Plan approval. Services shall be entered into ISIS based on the comprehensive service plan. A comprehensive service plan or treatment plan that has been validated and authorized through ISIS shall be considered approved by the department. Services must be authorized in ISIS as specified in paragraph 78.27(2) “e.”

78.27(5) Requirements for services. Home- and community-based habilitation services shall be provided in accordance with the following requirements:

a. The services shall be based on the member’s needs as identified in the member’s comprehensive service plan.

b. The services shall be delivered in the least restrictive environment appropriate to the needs of the member.

c. The services shall include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member’s life goals.

d. Service components that are the same or similar shall not be provided simultaneously.

e. Service costs are not reimbursable while the member is in a medical institution, including but not limited to a hospital or nursing facility.

f. Reimbursement is not available for room and board.

g. Services shall be billed in whole units.

h. Services shall be documented. Each unit billed must have corresponding financial and medical records as set forth in rule 441—79.3(249A).

78.27(6) Case management. Case management assists members in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Scope. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. Exclusions.

(1) Payment shall not be made for case management provided to a member who is enrolled for integrated health home services under rule 441—78.53(249A) except during the transition to the integrated health homes.

(2) Payment shall not be made for case management provided to a member who is eligible for case management services under 441—Chapter 90.

78.27(7) Home-based habilitation. “Home-based habilitation” means individually tailored supports that assist with the acquisition, retention, or improvement of skills related to living in the community.

a. Scope. Home-based habilitation services are individualized supportive services provided in the member’s home and community that assist the member to reside in the most integrated setting appropriate to the member’s needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member
shall be determined necessary by the interdisciplinary team and shall be identified in the member’s comprehensive service plan. Covered supports include:

1. Adaptive skill development;
2. Assistance with activities of daily living;
3. Community inclusion;
4. Transportation;
5. Adult educational supports;
6. Social and leisure skill development;
7. Personal care; and
8. Protective oversight and supervision.

b. Exclusions. Home-based habilitation payment shall not be made for the following:

1. Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.
2. Service activities associated with vocational services, day care, medical services, or case management.
3. Transportation to and from a day program.
4. Services provided to a member who lives in a licensed residential care facility of more than 16 persons.
5. Services provided to a member who lives in a facility that provides the same service as part of an inclusive or “bundled” service rate, such as a nursing facility or an intermediate care facility for persons with mental retardation.
6. Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

78.27(8) Day habilitation. “Day habilitation” means assistance with acquisition, retention, or improvement of self-help, socialization, and adaptive skills.

a. Scope. Day habilitation activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services focus on enabling the member to attain or maintain the member’s maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the comprehensive service plan. Services may serve to reinforce skills or lessons taught in other settings. Services must enhance or support the member’s:

1. Intellectual functioning;
2. Physical and emotional health and development;
3. Language and communication development;
4. Cognitive functioning;
5. Socialization and community integration;
6. Functional skill development;
7. Behavior management;
8. Responsibility and self-direction;
9. Daily living activities;
10. Self-advocacy skills; or
11. Mobility.

b. Setting. Day habilitation shall take place in community-based, nonresidential settings separate from the member’s residence.

c. Duration. Day habilitation services shall be furnished for four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the member’s comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

d. Exclusions. Day habilitation payment shall not be made for the following:

1. Vocational or prevocational services.
2. Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.
3. Compensation to members for participating in day habilitation services.
**78.27(9) Prevocational 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).
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.
5. Transportation coordination.
6. Job retention training and support.
7. Benefits education and ongoing support.
8. Supports for career advancement.
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.
7. Transportation planning and training.
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.

5. 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.

d. 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 240 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.

e. 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 30 consecutive days in any one stay. When a member has been an inpatient in a medical institution for 30 consecutive days, the department will issue a notice of decision to inform the member of the service termination. If the member returns home before the effective date of the notice of decision and the member’s condition has not substantially changed, the decision shall be rescinded, and eligibility for home- and community-based habilitation services shall continue.
6. The member’s service needs exceed the unit or reimbursement maximums for a service as established by the department.
7. Duplication of services provided during the same period has occurred.
8. The member or the member’s legal representative, through the interdisciplinary process, requests termination of the service.
9. Completion or receipt of required documents for the program has not occurred, or the member refuses to allow documentation of eligibility as to need and income.

d. **Appeal rights.** The department shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7. The member is entitled to have a review of the determination of needs-based eligibility by the Iowa Medicaid enterprise medical services unit by sending a letter requesting a review to the medical services unit. If dissatisfied with that decision, the member may file an appeal with the department.

**78.27(12) County reimbursement.** Rescinded IAB 7/11/12, effective 7/1/12.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); ARC 9311B, IAB 12/29/10, effective 1/1/11; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3874C, IAB 7/4/18, effective 8/8/18]

**441—78.28(249A) List of medical services and equipment requiring prior authorization, preprocedure review or preadmission review.**

**78.28(1) Services, procedures, and medications prescribed by a physician, physician assistant, or advanced registered nurse practitioner which are subject to prior authorization or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:**

a. Drugs require prior authorization as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A. For drugs requiring prior authorization, reimbursement will be made for a 72-hour supply dispensed in an emergency when a prior authorization request cannot be submitted.

b. Automated medication dispenser. Payment shall be approved pursuant to the criteria at 78.10(5)”d.”

c. Enteral products and enteral delivery pumps and supplies. Payment shall be approved pursuant to the criteria at 78.10(5)”l.”

d. Rescinded IAB 5/11/05, effective 5/1/05.

e. Speech generating device. Payment shall be approved pursuant to the criteria at 78.10(5)”f.”

f. Preprocedure review by the 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. Diabetic equipment and supplies. Payment will be approved pursuant to the criteria at 78.10(5)“e.”

l. Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved pursuant to the criteria at 78.10(5)“n.”

m. Bathtub/shower chair, bench. Payment shall be approved pursuant to the criteria at 78.10(5)“g.”

n. Patient lift, nonstandard. Payment shall be approved pursuant to the criteria at 78.10(5)“h.”

o. Power wheelchair attendant control. Payment shall be approved pursuant to the criteria at 78.10(5)“i.”

p. Shower commode chair. Payment shall be approved pursuant to the criteria at 78.10(5)“j.”

q. Ventilator, secondary. Payment shall be approved pursuant to the Medicare coverage criteria.

r. Customized wheelchairs, subject to the requirements of 78.10(2)“d.”

78.28(2) Dental services. Dental services which require prior approval are as follows:

a. The following periodontal services:
(1) Periodontal scaling and root planing. Payment will be approved pursuant to the criteria at 78.4(4)“b.”
(2) Pedicle soft tissue graft, free soft tissue graft, and subepithelial tissue graft. Payment will be approved pursuant to the criteria at 78.4(4)“d.”
(3) Periodontal maintenance therapy. Payment will be approved pursuant to the criteria at 78.4(4)“e.”
(4) Tissue regeneration. Payment will be approved pursuant to the criteria at 78.4(4)“f.”
(5) Localized delivery of antimicrobial agents. Payment will be approved pursuant to the criteria at 78.4(4)“g.”

b. The following prosthetic services:
(1) A removable partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“b.”
(2) A fixed partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“d.”
(3) A removable partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“c.”
(4) A fixed partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“e.”
(5) Dental implants and related services. Payment will be approved pursuant to the criteria at 78.4(7)“k.”
(6) Replacement of complete or partial dentures in less than a five-year period. Payment will be approved pursuant to the criteria at 78.4(7)“l.”
(7) A complete or partial denture rebase. Payment will be approved pursuant to the criteria at 78.4(7)“m.”
(8) An oral appliance for obstructive sleep apnea. Payment will be approved pursuant to the criteria at 78.4(7)“n.”
c. The following orthodontic services:
   (1) Minor treatment to control harmful habits. Payment will be approved pursuant to the criteria at 78.4(8) “a.”
   (2) Interceptive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8) “b.”
   (3) Comprehensive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8) “c.”

d. The following restorative services:
   (1) Laboratory-fabricated crowns other than stainless steel. Payment will be approved pursuant to the criteria at 78.4(3) “d”(3).
   (2) Crowns with noble or high noble metals. Payment will be approved pursuant to the criteria at 78.4(3) “d”(4).

e. Endodontic retreatment of a tooth. Payment will be approved pursuant to the criteria at 78.4(5) “d.”

f. Occlusal guard. Payment will be approved pursuant to the criteria at 78.4(9) “g.”

78.28(3) Optometric services and ophthalmic materials which must be submitted for prior approval are as follows:
   a. A second lens correction within a 24-month period for members eight years of age and older. Payment shall be made when the member’s vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.
   b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process should be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.
   c. Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles or reverse Galilean telescope systems.
   d. Photochromatic tint. Approval shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.
   e. Press-on prisms. Approval shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

For all of the above, the optometrist shall furnish sufficient information to clearly establish that these procedures are necessary in terms of the visual condition of the patient. (Cross references 78.6(4), 441—78.7(249A), and 78.1(18))

78.28(4) Hearing aids that must be submitted for prior approval are:
   a. Replacement of a hearing aid less than four years old (except when the member is under 21 years of age). The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person’s hearing that would require a different hearing aid. (Cross reference 78.14(7) “d”(1))
   b. A hearing aid costing more than $650. The department shall approve payment for either of the following purposes (Cross reference 78.14(7) “d”(2)):
      (1) Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.
      (2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise
or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

78.28(5) Hospital services which must be subject to prior approval, preprocedure review or preadmission review are:
   a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the hospital as long as the approval is obtained by the physician. (Cross reference 441—78.1(249A))
   b. All inpatient hospital admissions are subject to 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(6) Ambulatory surgical centers are subject to prior approval and preprocedure review as follows:
   a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the ambulatory surgical center as long as the prior approval is obtained by the physician.
   b. Preprocedure review by the IFMC is required if ambulatory surgical centers are to be reimbursed for surgical procedures as set forth in subrule 78.1(19). Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and criteria established by the IFMC and the department. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

78.28(7) All assertive community treatment (ACT) services require prior approval. EXCEPTION: If ACT services are initiated before Medicaid eligibility is established, prior approval is required for ACT services beginning with the second month following notice of Medicaid eligibility.
   a. Approval shall be granted if ACT services are determined to be medically necessary. Approval shall be limited to no more than 180 days.
   b. A new prior approval must be obtained to continue ACT services after the expiration of a previous approval.

78.28(8) 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(9) Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.
   a. Definitions.
   (1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member’s physician to a member in the member’s place of residence or outside the member’s residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.
Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child’s caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member.

Private duty nursing services do not include:
1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member’s household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.

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

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

b. Requirements.
1. Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician’s signature on the plan of care.
2. Private duty nursing or personal care services shall be authorized by the department or the department’s designated review agent prior to payment.
3. Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department’s designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department’s designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

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

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross reference 78.9(10))

78.28(10) Replacement of vibrotactile aids less than four years old shall be approved when the original aid is broken beyond repair or lost. (Cross reference 78.10(3)“b”)

78.28(11) High-technology radiology procedures.
a. Except as provided in paragraph 78.28(11) "b," the following radiology procedures require prior approval:
   (1) Magnetic resonance imaging (MRIs);
   (2) Computed tomography (CTs), including combined abdomen and pelvis CT scans;
   (3) Computed tomographic angiographs (CTAs);
   (4) Positron emission tomography (PETs); and
   (5) Magnetic resonance angiography (MRAs).

b. Notwithstanding paragraph 78.28(11) "a," prior authorization is not required when any of the following applies:
   (1) Radiology procedures are billed on a CMS 1500 claim for places of service “hospital inpatient” (POS 21) or “hospital emergency room” (POS 23), or on a UB04 claim with revenue code 45X;
   (2) The member has Medicare coverage;
   (3) The member received notice of retroactive Medicaid eligibility after receiving a radiology procedure at a time prior to the member’s receipt of such notice (see paragraph 78.28(11) “e”); or
   (4) A radiology procedure is ordered or requested by the department of human services, a state district court, law enforcement, or other similar entity for the purposes of a child abuse/neglect investigation, as documented by the provider.

c. Prior approval will be granted if the procedure requested meets the requirements of 441—subrule 79.9(2), based on diagnosis, symptoms, history of illness, course of treatment, and treatment plan, as documented by the provider requesting prior approval.

d. Required requests for prior approval of radiology procedures must be submitted through the online system operated by the department’s contractor for prior approval of high-technology radiology procedures.

e. Services are billed for members with retroactive eligibility.
   (1) When a member has received notice of retroactive Medicaid eligibility after receiving a radiology procedure for a date of service prior to the member’s receipt of such notice and otherwise requiring prior approval pursuant to this rule, a retroactive authorization request must be submitted on Form 470-0829, Request for Prior Authorization, before any claim for payment is submitted.

2. Payment will be authorized only if the prior approval criteria were met and the service was provided to the member prior to the retroactive eligibility notification, as documented by the provider requesting retroactive authorization.

3. Retroactive authorizations will not be granted when sought for reasons other than a member’s retroactive Medicaid eligibility. Examples of such reasons include, but are not limited to, the following:
   1. The provider was unaware of the high-technology radiology prior authorization requirement.
   2. The provider was unaware that the member had current Medicaid eligibility or coverage.
   3. The provider forgot to complete the required prior authorization process.

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

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, mallory-weiss tears, decreased gastric emptying, constipation, abnormal liver enzymes, rectal bleeding, laxative abuse, or esophagitis.

Hematologic considerations including anemia, leukopenia, or thrombocytopenia.

Ear, nose, and throat factors including headaches or dizziness.

Skin considerations including lanugo or dry skin.

Aspiration pneumonia, a pulmonary factor.

The presence of severe symptoms and complications as evaluated and documented by the medical director may require a period of hospitalization to establish physical or emotional stability.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient’s perceptions of needs and, when appropriate and available, the family’s perceptions of the patient’s needs shall be documented.

The patient’s participation in the development of the treatment plans is sought and documented.
Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

6. Discharge plan. Plans for discharge shall meet the requirements for discharge plans for alcohol and substance abuse patients in subrule 78.31(3), paragraph “a,” subparagraph (6).

7. Restriction and limitations on payment. Medicaid will pay for a maximum of 30 days of a structured outpatient treatment program. Payment beyond 30 days is made when documentation indicates that the patient has not reached an exit level.

Eating disorder programs will include an aftercare component meeting weekly for at least one year without charge.

Family counseling groups held in conjunction with the eating disorders program will be part of the overall treatment charge.

c. Cardiac rehabilitation.

1. General characteristics. Cardiac rehabilitation programs shall provide a supportive educational environment in which to facilitate behavior change with respect to the accepted cardiac risk factors, initiate prescribed exercise as a mode of facilitating the return of the patient to everyday activities by improving cardiovascular functional capacity and work performance, and promote a long-term commitment to lifestyle changes that could positively affect the course of the cardiovascular disease process.

2. Treatment staff. Professional disciplines who must be represented on the treatment staff, either by employment by the facility (full-time or part-time), contract or referral, are as follows:

At least one physician responsible for responding to emergencies must be physically present in the hospital when patients are receiving cardiac rehabilitation services. The physician must be trained and certified at least to the level of basic life support.

A medical consultant shall oversee the policies and procedures of the outpatient cardiac rehabilitation area. The director shall meet with the cardiac rehabilitation staff on a regular basis to review exercise prescriptions and any concerns of the team.

A cardiac rehabilitation nurse shall carry out the exercise prescription after assessment of the patient. The nurse shall be able to interpret cardiac disrythmia and be able to initiate emergency action if necessary. The nurse shall assess and implement a plan of care for cardiac risk factor modification. The nurse shall have at least one year of experience in a coronary care unit.

A physical therapist shall offer expertise in unusual exercise prescriptions where a patient has an unusual exercise problem.

A dietitian shall assess the dietary needs of persons and appropriately instruct them on their prescribed diets.

A social worker shall provide counseling as appropriate and facilitate a spouse support group. A licensed occupational therapist shall be available as necessary.

3. Admission criteria. Candidates for the program must be referred by the attending physician. The following conditions are eligible for the program:

Postmyocardial infarction (within three months postdischarge).
Postcardiac surgery (within three months postdischarge).
Poststreptokinase.
Postpercutaneous transluminal angioplasty (within three months postdischarge).
Patient with severe angina being treated medically because of client or doctor preference or inoperable cardiac disease.

4. Physical environment and equipment. A cardiac rehabilitation unit must be an autonomous physical unit specifically equipped with the necessary telemetry monitoring equipment, exercise equipment, and appropriate equipment and supplies for cardiopulmonary resuscitation (CPR). The exercise equipment must have the capacity to measure the intensity, speed, and length of the exercises. The equipment must be periodically inspected and maintained in accordance with the hospital’s preventive maintenance program.

5. Medical records. Medical records for each cardiac rehabilitation patient shall consist of at least the following:
Referral form.
Physician’s orders.
Laboratory reports.
Electrocardiogram reports.
History and physical examination.
Angiogram report, if applicable.
Operative report, if applicable.
Preadmission interview.
Exercise prescription.
Rehabilitation plan, including participant’s goals.
Documentation for exercise sessions and progress notes.
Nurse’s progress reports.
Discharge instructions.

(6) Discharge plan. The patient will be discharged from the program when the physician, staff, and patient agree that the work level is functional for them and little benefit could be derived from further continuation of the program, disrhythmia disturbances are resolved, and appropriate cardiovascular response to exercise is accomplished.

(7) Monitoring of services. The program should be monitored by the hospital on a periodic basis using measuring criteria for evaluating cardiac rehabilitation services provided.

(8) Restrictions and limitations. Payment will be made for a maximum of three visits per week for a period of 12 weeks. Payment beyond 12 weeks is made when documentation indicates that the patient has not reached an exit level.

d. Mental health.

(1) General characteristics. To be covered, mental health services must be prescribed by a physician or certified health service provider in psychology, provided under an individualized treatment plan and reasonable and necessary for the diagnosis or treatment of the patient’s condition. This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient’s condition.

(2) Individualized treatment plan. The individualized written plan of treatment shall be established by a physician or certified health service provider in psychology after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)

(3) Supervision and evaluation. Services must be supervised and periodically evaluated by a physician, certified health service provider in psychology, or both within the scopes of their respective practices if clinically indicated to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff. The physician or certified health service provider in psychology must also provide supervision and direction to any therapist involved in the patient’s treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or services are required.

(4) Reasonable expectation of improvement. Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient’s condition. The treatment must at a minimum be designed to reduce or control the patient’s psychiatric or psychological symptoms so as to prevent relapse or hospitalization and improve or maintain the patient’s level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness although this may be appropriate for some patients. For many other patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. “Improvement” in this context is measured by comparing the effect of continuing versus discontinuing treatment. Where there is a reasonable expectation that if
treatment services were withdrawn, the patient’s condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

(5) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. The number of the above staff employed by the facility must be appropriate to the facility’s patient load. The staff may be employees of the hospital, on contract, or the service may be provided through referral.

The diagnostic and treatment staff shall consist of a physician, a psychologist, social workers or counselors meeting the requirements for “mental health professionals” as set forth in rule 441—33.1(225C,230A).

(6) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted, which shall include:

A history of the mental health problem, including age of onset, duration, patterns of symptoms, consequences of symptoms, and responses to previous treatment.

A comprehensive clinical history, including the history of physical problems associated with the mental health problem. Appropriate referral for physical examination for determination of any communicable diseases.

Any history of physical abuse.

A systematic mental health examination, with special emphasis on any change in cognitive, social or emotional functioning.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family’s history of mental health problems.

The patient’s educational level, vocational status, and job performance history.

The patient’s social support network, including family and peer relationship.

The patient’s perception of the patient’s strengths, problem areas, and dependencies.

The patient’s leisure, recreational or vocational interests and hobbies.

The patient’s ability to participate with peers in programs and social activities.

Interview of family members and significant others, as available, with the patient’s written or verbal permission.

Legal problems if applicable.

(7) Covered services. Services covered for the treatment of psychiatric conditions are:

1. Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses.

2. Occupational therapy services if the services require the skills of a qualified occupational therapist and must be performed by or under the supervision of a licensed occupational therapist or by an occupational therapy assistant.

3. Drugs and biologicals furnished to outpatients for therapeutic purposes only if they are of the type which cannot be self-administered and are not “covered Part D drugs” as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a “Part D eligible individual” as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

4. Activity therapies which are individualized and essential for the treatment of the patient’s condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient’s treatment.

5. Family counseling services are covered only if the primary purpose of the counseling is the treatment of the patient’s condition.

6. Partial hospitalization and day treatment services to reduce or control a person’s psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the person’s level of functioning and minimize regression. These services include all psychiatric services needed by the patient during the day.

Partial hospitalization services means an active treatment program that provides intensive and structured support that assists persons during periods of acute psychiatric or psychological distress or during transition periods, generally following acute inpatient hospitalization episodes.
Service components may include individual and group therapy, reality orientation, stress management and medication management.

Services are provided for a period for four to eight hours per day.

Day treatment services means structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression and preventing hospitalization.

Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions, and training in medication management.

Services are structured with an emphasis on program variation according to individual need.

Services are provided for a period of three to five hours per day, three or four times per week.

7. Partial hospitalization and day treatment for persons aged 20 or under. Payment to a hospital will be approved for day treatment services for persons aged 20 or under if the hospital is certified by the department for hospital outpatient mental health services. All conditions for the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall apply to hospitals. All conditions of the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall be applicable for the partial hospitalization program for persons aged 20 or under with the exception that the maximum hours shall be 25 hours per week.

8. Restrictions and limitations on coverage. The following are generally not covered except as indicated:

Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

Geriatric day-care programs, which provide social and recreational activities to older persons who need some supervision during the day while other family members are away from home. These programs are not covered because they are not considered reasonable and necessary for a diagnosed psychiatric disorder.

Vocational training. While occupational therapy may include vocational and prevocational assessment of training, when the services are related solely to specific employment opportunities, work skills, or work setting, they are not covered.

9. Frequency and duration of services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment. Among them are the nature of the illness, prior history, the goals of treatment, and the patient’s response. As long as the evidence shows that the patient continues to show improvement in accordance with the individualized treatment plan and the frequency of services is within acceptable norms of medical practice, coverage will be continued.

10. Documentation requirements. The provider shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. All outpatient mental health services shall include:

1. The specific services rendered.
2. The date and actual time the services were rendered.
3. Who rendered the services.
4. The setting in which the services were rendered.
5. The amount of time it took to deliver the services.
6. The relationship of the services to the treatment regimen described in the plan of care.
7. Updates describing the patient’s progress.

For services that are not specifically included in the patient’s treatment plan, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient’s plan of care and the reason for the departure from the plan shall be given.

e. Pain management.

1. Approval by commission on accreditation of rehabilitation facilities. In addition to certification by the department, pain management programs must also be approved by the commission on accreditation of rehabilitation facilities (CARF).
(2) General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

(3) Treatment staff. Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. Professional disciplines which must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a licensed physical therapist and a licensed clinical psychologist or psychiatrist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches.

The person must be free of any underlying psychosis or severe neurosis.

The person cannot be toxic on any addictive drugs.

The person must be capable of self-care; including being able to get to meals and to perform activities of daily living.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the times at which the plan will be reassessed.

The patient’s perception of needs and, when appropriate and available, the family’s perception of the patient’s needs shall be documented.

The patient’s participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient’s continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient’s personal support system.

The plan is in accordance with the patient’s reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient’s written verbal permission with the family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the patient has not reached an exit level, coverage may be extended an extra week.

A repeat of the entire program for any patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

f. Diabetic education.

(1) Certification by department of public health. In addition to certification by the department for Medicaid, diabetic education programs must also be certified by the department of public health. (See department of public health rules 641—Chapter 9.)

(2) General characteristics. An outpatient diabetes self-management education program shall provide instruction which will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes. People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to
self-treat insulin reactions, protect feet that are numb and have seriously compromised circulation, and accommodate their regimen to changes in blood glucose because of stress or infections.

(3) Program staff. Each person who provides services shall be determined to be competent to provide the services by reason of education, training and experience. Professional disciplines which must be represented on the staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a registered dietitian and a licensed pharmacist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:
   The person must have Type I or Type II diabetes.
   The person must be referred by the attending physician.
   The person shall demonstrate an ability to follow through with self-management.

(5) Health assessment. An individualized and documented assessment of needs shall be developed with the patient’s participation. Follow-up assessments, planning and identification of problems shall be provided.

(6) Restrictions and limitations on payment. Medicaid will pay for a diabetic self-management education program. Diabetic education programs will include follow-up assessments at 3 and 12 months without charge. A complete diabetic education program is payable once in the lifetime of a recipient.

   g. Pulmonary rehabilitation.

   (1) General characteristics. Pulmonary rehabilitation is an individually tailored, multidisciplinary program through which accurate diagnosis, therapy, emotional support, and education stabilizes or reverses both the physio- and psychopathology of pulmonary diseases and attempts to return the patient to the highest possible functional capacity allowed by the pulmonary handicap and overall life situation.

   (2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

   Professional disciplines which must be represented by the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract, or referral, are a physician (doctor of medicine or osteopathy), a respiratory therapist, a licensed physical therapist, and a registered nurse.

   (3) Initial assessment. A comprehensive assessment must occur initially, including:

   A diagnostic workup which entails proper identification of the patient’s specific respiratory ailment, appropriate pulmonary function studies, a chest radiograph, an electrocardiogram and, when indicated, arterial blood gas measurements at rest and during exercise, sputum analysis and blood theophylline measurements.

   Behavioral considerations include emotional screening assessments and treatment or counseling when required, estimating the patient’s learning skills and adjusting the program to the patient’s ability, assessing family and social support, potential employment skills, employment opportunities, and community resources.

   (4) Admission criteria. Criteria include a patient’s being diagnosed and symptomatic of chronic obstructive pulmonary disease (COPD), having cardiac stability, social, family, and financial resources, ability to tolerate periods of sitting time; and being a nonsmoker for six months, or if a smoker, willingness to quit and a physician’s order to participate anyway.

   Factors which would make a person ineligible include acute or chronic illness that may interfere with rehabilitation, any illness or disease state that affects comprehension or retention of information, a strong history of medical noncompliance, unstable cardiac or cardiovascular problems, and orthopedic difficulties that would prohibit exercise.

   (5) Plan of treatment. Individualized long- and short-term goals will be developed for each patient. The treatment goals will be based on the problems and needs identified in the assessment and specify the regular times at which the plan will be reassessed.

   The patient’s 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 dietician employed by or under contract with a hospital for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.31(5) Services rendered by advanced registered nurse practitioners certified in family, pediatric, or psychiatric mental health specialties and employed by a hospital. Rescinded IAB 10/15/03, effective 12/1/03.

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—78.32(249A) Area education agencies. Payment will be made for physical therapy, occupational therapy, psychological evaluations and counseling, psychotherapy, speech-language therapy, and audiological, nursing, and vision services provided by an area education agency (AEA). Services shall be provided directly by the AEA or through contractual arrangement with the AEA.

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

441—78.33(249A) Case management services. Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

1. Members who are 18 years of age or over and have a primary diagnosis of intellectual disability, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).

2. Members who are under 18 years of age and are receiving services under the HCBS intellectual disability waiver or children’s mental health waiver.

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

[ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9588B, IAB 6/29/11, effective 9/1/11; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—78.34(249A) HCBS ill and handicapped waiver services. Payment will be approved for the following services to members eligible for HCBS ill and handicapped waiver services as established in 441—Chapter 83 and as identified in the member’s service plan. 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 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) “g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

1. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:
   1. Select the individual or agency that will provide the components of the attendant care services.
   2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.
   3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.
   4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

2. Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “b,” the following shall apply:
   1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;
   2. The legal representative may not be paid for more than 40 hours of service per week; and
   3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

1. Retain accountability for actions that are delegated.
2. Ensure appropriate assessment, planning, implementation, and evaluation.
3. Make on-site supervisory visits every two weeks with the service provider present.
c. **Service documentation.** The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. **Role of guardian or attorney.** If the member has a guardian or attorney in fact under a durable power of attorney for health care:

1. The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

2. The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. **Service units and billing.** A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. **Nonskilled services.** Covered nonskilled service activities are limited to help with the following activities:

1. Dressing.
2. Bathing, shampooing, hygiene, and grooming.
3. Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
4. Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
5. Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member’s home.
6. Housekeeping, laundry, and shopping essential to the member’s health care at home.
7. Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
8. Minor wound care.
9. Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
10. Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
11. Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
12. Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. **Skilled services.** Covered skilled service activities are limited to help with the following activities:

1. Tube feedings of members unable to eat solid foods.
2. Intravenous therapy administered by a registered nurse.
3. Parenteral injections required more than once a week.
4. Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
5. Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
6. Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
7. Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
8. Colostomy care.
9. Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
(10) Postsurgical nursing care.
(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
(12) Preparing and monitoring response to therapeutic diets.
(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.
(2) Any activity that the member is able to perform.
(3) Costs of food.
(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
(5) Exercise that does not require skilled services.
(6) Parenting or child care for or on behalf of the member.
(7) Reminders and cueing.
(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
(9) Transportation costs.
(10) Wait times for any activity.

78.34(8) Interim medical monitoring and treatment services. Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member’s living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member’s usual caregivers to be employed,
(2) During a search for employment by a usual caregiver,
(3) To allow for academic or vocational training of a usual caregiver,
(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member’s social, emotional, intellectual, and physical development;
(2) Include comprehensive developmental care and any special services for a member with special needs; and
(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.
(2) Covered services do not include a complete nutritional regimen.
(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided 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.

c. 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.
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.
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 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.

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.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member’s service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.
23. Services provided in the family home by a parent, stepparent, legal representative, sibling, or stepsibling during overnight sleeping hours unless the parent, stepparent, legal representative, sibling, or stepsibling is awake and actively providing direct services as authorized in the member’s service plan.
24. Residential services provided to three or more members living in the same residential setting.

4. The costs of any approved home or vehicle modification, assistive device, or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification, an assistive device, or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications, assistive devices, and specialized medical equipment shall be identified in the member’s service plan and approved by the case manager or community-based case manager. The authorized amount shall not be used for anything other than the specific modification, assistive device, or specialized medical equipment, as identified in subparagraph 78.34(13)“b’”(11).

5. Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.34(13)“d.” The savings plan shall meet the requirements in paragraph 78.34(13)“f.”

f. Savings plan. A member savings plan must be in writing and be approved before the start of the savings plan by the department for fee-for-service members or by the member’s managed care organization for members in managed care. Budget amounts allocated to the savings plan must result from efficiencies in meeting the member’s service needs identified in the member’s service plan.

1. The savings plan shall identify:
   1. The specific goods, services, supports or supplies to be purchased through the savings plan.
   2. The amount of the individual budget allocated each month to the savings plan.
   3. The amount of the individual budget allocated each month to meet the member’s identified service needs.
   4. How the member’s assessed needs will continue to be met through the individual budget when funds are placed in savings.
5. Specific time spans for accumulating the savings allocation, not to exceed the member’s current service plan year end date.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services or supports that were not received. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds allocated to a savings plan may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services included in the monthly budget may exceed the amount of service or supports authorized in the member’s service plan. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member’s identified need,
2. Be medically necessary, and
3. Be approved by the member’s case manager or community-based case manager.

(4) All funds allocated to a savings plan to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services must be used during the member’s waiver year in which the saving occurred.

(5) The annual reassessment of a member’s needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department or managed care organization to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates for employees shall be consistent with employee reimbursement rates or the prevailing wages paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the member’s employee is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget. When the member’s guardian or legal representative is a paid employee, payment authorization for optional service components must be delegated to a representative pursuant to paragraph 78.34(13)“i.”

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the CCO. A common-law employer has the right to direct and control the performance of the services. If the member is a child, the parent or the legal representative shall be responsible for completing all employer authority tasks. Adult members who do not have the ability to complete all employer authority tasks shall have a representative delegated to complete the employer authority tasks identified in this paragraph. Documentation of the person responsible for the employer authority tasks, whether the member or another entity, shall be included in the member’s service plan. The member or the delegated employer authority may perform the following functions:

(1) Recruit and hire employees.
(2) Verify employee qualifications.
(3) Specify additional employee qualifications.
(4) Determine employee duties.
(5) Determine employee wages and benefits.
(6) Schedule employees.
(7) Train and supervise employees.
i. Delegation of budget and employer authority. The member may delegate responsibilities for the individual budget or employer authority functions to a representative. If the member is a child, the parent or the legal representative shall be delegated all budget and employer authority tasks. Adult members aged 18 and older who do not have the ability to complete all budget or employer authority tasks shall have a representative delegated to complete the applicable budget authority tasks identified in paragraph 78.34(13)“g” and employer authority tasks identified in paragraph 78.34(13) “h.” Documentation of the person responsible for the budget and employer authority tasks, whether the member or a representative, shall be included in the member’s service plan.

1. The representative must be at least 18 years old.
2. The representative shall not be a current provider of service to the member.
3. The member shall sign a consent form that designates who the member has chosen as a representative and the responsibilities of the representative.
4. The representative shall not be paid for this service.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee’s and member’s responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member’s representative:

1. Assist the member with developing the member’s initial and subsequent individual budgets and with making any changes to the individual budget.
2. Have monthly contact with the member for the first four months of implementation of the initial individual budget and have, at a minimum, quarterly contact thereafter.
3. Complete the required employment packet with the financial management service.
4. Assist with interviewing potential employees and entities providing services and supports if requested by the member.
5. Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
6. Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
7. Assist the member with negotiating with entities providing services and supports if requested by the member.
8. Assist the member with contracts and payment methods for services and supports if requested by the member.
9. Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
10. Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
11. Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member’s individual budget has addressed the member’s needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

1. Receive Medicaid funds in an electronic transfer.
2. Process and pay invoices for approved goods and services included in the individual budget.
3. Monitor and track the approved individual budget amount authorized each month and document all expenditures as they are paid.
4. Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
5. Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
6. Verify for the member an employee’s citizenship or alien status.
7. Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee’s pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member’s employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state’s quality management strategy related to the financial management service.

(18) The department may request that the financial management service provider withhold payment to any member or member’s employee to offset any overpayment or enforce any sanction placed on the service provider pursuant to rule 441—79.3(249A).

m. Responsibilities of the member and the employee. A member participating in the CCO and the member’s employee(s) are responsible for the following:

(1) A member participating in the CCO shall be jointly and severally liable with any of the member’s employees for any overpayment of medical assistance funds used through a CCO budget.

(2) A member may not employ any person who has been sanctioned, or who is affiliated with a person or an entity that has been sanctioned, under 441—Chapter 79. For purposes of this subparagraph, “sanction” also includes anyone who has been temporarily suspended for a credible allegation of fraud under 42 CFR Part 455. Any CCO funds paid to any employee who or which has been sanctioned is an overpayment that the department shall recoup under 441—Chapter 79.

(3) A member may not employ any person who has been excluded by the Office of the Inspector General of the Department of Health and Human Services under Sections 1128 or 1156 of the Social Security Act and is not eligible to receive federal funds.

(4) 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. Documentation shall comport with 441—subparagraph 79.3(2)“c”(3), “Service documentation.”

(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 ill and handicapped waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member’s service plan.

c. 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 2/17/17, effective 5/8/17; 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]

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.


(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers’ compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member’s service plan and shall exceed the Medicaid state plan services.

78.37(10) Mental health outreach. Mental health outreach services are services provided in a recipient’s home to identify, evaluate, and provide treatment and psychosocial support. The services can only be provided on the basis of a referral from the consumer’s interdisciplinary team established pursuant to 441—subrule 83.22(2). A unit of service is 15 minutes.

78.37(11) Transportation. Transportation services may be provided for members to conduct business errands and essential shopping and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.37(12) Nutritional counseling. Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.37(13) Assistive devices. Assistive devices means practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence. They include, but are not limited to: long-reach brush, extra long shoehorn, nonslip grippers to pick up and reach items, dressing aids, shampoo rinse tray and inflatable shampoo tray, double-handled cup and sipper lid. A unit is an item.

a. The service shall be included in the member’s service plan and shall exceed the services available under the Medicaid state plan.

b. The service shall be provided following prior approval by the Iowa Medicaid enterprise.

c. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).
78.37(14) Senior companion. Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is 15 minutes.

78.37(15) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.37(15)"f" and the skilled activities listed in paragraph 78.37(15)"g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

   a. Service planning.
      (1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:
         1. Select the individual, agency or assisted living facility that will provide the components of the attendant care services.
         2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.
         3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.
         4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

   (2) Assisted living agreements with Iowa Medicaid members must specify the services to be considered covered under the assisted living occupancy agreement and those CDAC services to be covered under the elderly waiver. The funding stream for each service must be identified.

   (3) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)"b," the following shall apply:
      1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;
      2. The legal representative may not be paid for more than 40 hours of service per week; and
      3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

   b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:
      (1) Retain accountability for actions that are delegated.
      (2) Ensure appropriate assessment, planning, implementation, and evaluation.
      (3) Make on-site supervisory visits every two weeks with the service provider present.

   c. Service documentation. The consumer-directed attendant care individual and agency providers must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Assisted living facilities may choose to use Form 470-4389 or may devise another system that adheres to the requirements of rule 441—79.3(249A). Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

   d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:
(1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual, agency or assisted living facility. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.
(2) Bathing, shampooing, hygiene, and grooming.
(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member’s home.
(6) Housekeeping, laundry, and shopping essential to the member’s health care at home.
(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
(8) Minor wound care.
(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.
(2) Intravenous therapy administered by a registered nurse.
(3) Parenteral injections required more than once a week.
(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
(8) Colostomy care.
(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
(10) Postsurgical nursing care.
(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
(12) Preparing and monitoring response to therapeutic diets.
(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.
(2) Any activity that the member is able to perform.
(3) Costs of food.
(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
(5) Exercise that does not require skilled services.
(6) Parenting or child care for or on behalf of the member.
(7) Reminders and cueing.
(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
(9) Transportation costs.
(10) Wait times for any activity.

78.37(16) Consumer choices option. The consumer choices option 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—90.5(249A) and 441—90.8(249A).

b. Case management shall not include the provision of direct services by the case managers.

c. Payment for case management shall not be made until the consumer is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the consumer during a month when the consumer is enrolled.

78.37(18) Assisted living 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.

c. 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.

d. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member’s service plan.

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.
\text{d.} \quad \text{Services must be billed in whole units.}
\text{e.} \quad \text{For all services with a 15-minute unit of service, the following rounding process will apply:}
\begin{enumerate}
\item Add together the minutes spent on all billable activities during a calendar day for a daily total.
\item 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.
\item Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
\item 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.
\end{enumerate}

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

\begin{itemize}
\item [ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 9845B, 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 0790C, 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]
\end{itemize}

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.

\textbf{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.

\textbf{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:

\begin{itemize}
\item [a. Observation and reporting of physical or emotional needs.]
\end{itemize}
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 must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member’s home.

(6) Housekeeping, laundry, and shopping essential to the member’s health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.
(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.38(9) Consumer choices option. The consumer choices option 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]

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.

(3) 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.


(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 must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

   (1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

   (2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.
f. **Nonskilled services.** Covered nonskilled service activities are limited to help with the following activities:

1. Dressing.
2. Bathing, shampooing, hygiene, and grooming.
3. Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
4. Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
5. Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member’s home.
6. Housekeeping, laundry, and shopping essential to the member’s health care at home.
7. Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
8. Minor wound care.
9. Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
10. Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
11. Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
12. Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. **Skilled services.** Covered skilled service activities are limited to help with the following activities:

1. Tube feedings of members unable to eat solid foods.
2. Intravenous therapy administered by a registered nurse.
3. Parenteral injections required more than once a week.
4. Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
5. Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
6. Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
7. Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
8. Colostomy care.
9. Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
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.
13. Recording and reporting of changes in vital signs to the nurse or therapist.

h. **Excluded services and costs.** Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

1. Any activity related to supervising a member. Only direct services are billable.
2. Any activity that the member is able to perform.
3. Costs of food.
4. Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may
be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

   (5) Exercise that does not require skilled services.
   (6) Parenting or child care for or on behalf of the member.
   (7) Reminders and cueing.
   (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
   (9) Transportation costs.
   (10) Wait times for any activity.

78.41(9) Interim medical monitoring and treatment services. Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

   a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member’s living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:
      (1) To allow the member’s usual caregivers to be employed,
      (2) During a search for employment by a usual caregiver,
      (3) To allow for academic or vocational training of a usual caregiver,
      (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
      (5) Due to the death of a usual caregiver.

   b. Service requirements. Interim medical monitoring and treatment services shall:
      (1) Provide experiences for each member’s social, emotional, intellectual, and physical development;
      (2) Include comprehensive developmental care and any special services for a member with special needs; and
      (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

   c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

   d. Limitations.
      (1) A maximum of 12 hours of service is available per day.
      (2) Covered services do not include a complete nutritional regimen.
      (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.
      (4) Interim medical monitoring and treatment services shall be provided 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 services.
a. **Scope.** Day habilitation services are services that assist or support the member in developing or maintaining life skills and community integration. Services must enable or enhance the member’s intellectual functioning, physical and emotional health and development, language and communication development, cognitive functioning, socialization and community integration, functional skill development, behavior management, responsibility and self-direction, daily living activities, self-advocacy skills, or mobility.

b. **Family training option.** Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the member’s home. The unit of service is 15 minutes. The units of services payable are limited to a maximum of 40 units per month.

c. **Unit of service.** Except as provided in paragraph 78.41(14) “b,” the unit of service is 15 minutes (for up to 16 units per day) or a full day (4.25 to 8 hours per day).

d. **Exclusions.**
   1. Services shall not be provided in the member’s home, except as provided in paragraph “b.” For this purpose, services provided in a residential care facility where the member lives are not considered to be provided in the member’s home.
   2. Services shall not include vocational or prevocational services and shall not involve paid work.
   3. Services shall not duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.
   4. Services shall not be provided simultaneously with other Medicaid-funded services.

78.41(15) **Consumer choices option.** The consumer choices option 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 8/3/14; ARC 1250C, 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 1/2/17, 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]

441—78.42(249A) Pharmacies administering influenza vaccine to children. Payment will be made to a pharmacy for the administration of influenza vaccine available through the Vaccines for Children (VFC) Program administered by the department of public health if the pharmacy is enrolled in the VFC program. Payment will be made for the vaccine only if the VFC program stock has been depleted.

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

[ARC 9132B, IAB 10/6/10, effective 11/1/10; ARC 9316B, IAB 12/29/10, effective 2/2/11; ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.43(249A) HCBS brain injury waiver services. Payment shall be approved for the following services to members eligible for the HCBS brain injury waiver services as established in 441—Chapter 83 and as identified in the member’s service plan. 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 living, 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—90.5(249A) and 441—90.8(249A).

b. The service shall be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.

c. The case manager must develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers.

d. Members who are eligible for targeted case management are not eligible for case management as a waiver service.

78.43(2) Supported community living services. Supported community living services are provided by the provider within the member’s home and community, according to the individualized member need as identified in the service plan.

a. The basic components of the service may include, but are not limited to, personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member’s rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member’s needs.
(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member’s personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

4. Personal and environmental support services are those activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

5. Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life’s activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441-78.13(249A).

6. Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member’s functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

   1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

   2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member’s functioning in response to the physical, emotional, and social environment.

      a. 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.
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.

de. 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.

d. 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.

e. 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-activated, 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.
   (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 must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. *Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:
   (1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.
   (2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. *Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. *Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:
   (1) Dressing.
   (2) Bathing, shampooing, hygiene, and grooming.
   (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
   (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
   (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member’s home.
   (6) Housekeeping, laundry, and shopping essential to the member’s health care at home.
   (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
   (8) Minor wound care.
   (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
   (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
   (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
   (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. *Skilled services.* Covered skilled service activities are limited to help with the following activities:
   (1) Tube feedings of members unable to eat solid foods.
   (2) Intravenous therapy administered by a registered nurse.
   (3) Parenteral injections required more than once a week.
   (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
(8) Colostomy care.
(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
(10) Postsurgical nursing care.
(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
(12) Preparing and monitoring response to therapeutic diets.
(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. **Excluded services and costs.** Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

1. Any activity related to supervising a member. Only direct services are billable.
2. Any activity that the member is able to perform.
3. Costs of food.
4. Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
5. Exercise that does not require skilled services.
6. Parenting or child care for or on behalf of the member.
7. Reminders and cueing.
8. Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
9. Transportation costs.
10. Wait times for any activity.

**78.43(14) Interim medical monitoring and treatment services.** Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member’s living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

1. To allow the member’s usual caregivers to be employed,
2. During a search for employment by a usual caregiver,
3. To allow for academic or vocational training of a usual caregiver,
4. Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
5. Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

1. Provide experiences for each member’s social, emotional, intellectual, and physical development;
(2) Include comprehensive developmental care and any special services for a member with special needs; and
(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.
   c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.
   d. Limitations.
      (1) A maximum of 12 hours of service is available per day.
      (2) Covered services do not include a complete nutritional regimen.
      (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.25(4), 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.
   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.
   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]

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 9404B, 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) “a” and the skilled activities listed in paragraph 78.46(1) “g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

   a. Service planning.
(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:
   1. Select the individual or agency that will provide the components of the attendant care services.
   2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.
   3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.
   4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “b,” the following shall apply:
   1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;
   2. The legal representative may not be paid for more than 40 hours of service per week; and
   3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:
   (1) Retain accountability for actions that are delegated.
   (2) Ensure appropriate assessment, planning, implementation, and evaluation.
   (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:
   (1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.
   (2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:
   (1) Dressing.
   (2) Bathing, shampooing, hygiene, and grooming.
   (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
   (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
   (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member’s home.
   (6) Housekeeping, laundry, and shopping essential to the member’s health care at home.
(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
(8) Minor wound care.
(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

\textit{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.

\textit{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.
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.
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]

441—78.47(249A) Pharmaceutical case management services. Payment will be approved for pharmaceutical case management services provided by an eligible physician and pharmacist for Medicaid recipients determined to be at high risk for medication-related problems. These services are designed to identify, prevent, and resolve medication-related problems and improve drug therapy outcomes.

78.47(1) Medicaid recipient eligibility. Patients are eligible for pharmaceutical case management services if they have active prescriptions for four or more regularly scheduled nontopical medications, are ambulatory, do not reside in a nursing facility, and have at least one of the eligible disease states of congestive heart disease, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux, or chronic obstructive pulmonary disease.

78.47(2) Provider eligibility. Physicians and pharmacists shall meet the following criteria to provide pharmaceutical case management services.

a. Physicians and pharmacists must be enrolled in the Iowa Medicaid program, have an Iowa Medicaid provider number, and receive training under the direction of the department regarding the provision of pharmaceutical case management services under the Iowa Medicaid program.
A copy of pharmaceutical case management records, including documentation of services provided, shall be maintained on file in each provider’s facility and be made available for audit by the department on request.

b. Physicians shall be licensed to practice medicine.

c. Pharmacists shall present to the department evidence of competency including state licensure, submit five acceptable patient care plans, and have successfully completed professional training on patient-oriented, medication-related problem prevention and resolution. Pharmacists shall also maintain problem-oriented patient records, provide a private patient consultation area, and submit a statement indicating that the submitted patient care plans are representative of the pharmacists’ usual patient care plans.

Acceptable professional training programs are:

(1) A doctor of pharmacy degree program.

(2) The Iowa Center for Pharmaceutical Care (ICPC) training program, which is a cooperative training initiative of the University of Iowa College of Pharmacy, Drake University College of Pharmacy and Health Sciences, and the Iowa Pharmacy Foundation.

(3) Other programs containing similar coursework and supplemental practice site evaluation and reengineering, approved by the department with input from a peer review advisory committee.

78.47(3) Services. Eligible patients may choose whether to receive the services. If patients elect to receive the services, they must receive the services from any eligible physician and pharmacist acting as a pharmaceutical case management (PCM) team. Usually the eligible physician and pharmacist will be the patient’s primary physician and pharmacist. Pharmaceutical case management services are to be value-added services complementary to the basic medical services provided by the primary physician and pharmacist.

The PCM team shall provide the following services:

a. Initial assessment. The initial assessment shall consist of:

(1) A patient evaluation by the pharmacist, including:
   1. Medication history;
   2. Assessment of indications, effectiveness, safety, and compliance of medication therapy;
   3. Assessment for the presence of untreated illness; and
   4. Identification of medication-related problems such as unnecessary medication therapy, suboptimal medication selection, inappropriate compliance, adverse drug reactions, and need for additional medication therapy.

(2) A written report and recommendation from the pharmacist to the physician.

(3) A patient care action plan developed by the PCM team with the patient’s agreement and implemented by the PCM team. Specific components of the action plan will vary based on patient needs and conditions but may include changes in medication regimen, focused patient or caregiver education, periodic assessment for changes in the patient’s condition, periodic monitoring of the effectiveness of medication therapy, self-management training, provision of patient-specific educational and informational materials, compliance enhancement, and reinforcement of healthy lifestyles. An action plan must be completed for each initial assessment.

b. New problem assessments. These assessments are initiated when a new medication-related problem is identified. The action plan is modified and new components are implemented to address the new problem. This assessment may occur in the interim between scheduled follow-up assessments.

c. Problem follow-up assessments. These assessments are based on patient need and a problem identified by a prior assessment. The patient’s status is evaluated at an appropriate interval. The effectiveness of the implemented action plan is determined and modifications are made as needed.

d. Preventive follow-up assessments. These assessments occur approximately every six months when no current medication-related problems have been identified in prior assessments. The patient is reassessed for newly developed medication-related problems and the action plan is reviewed.

This rule is intended to implement Iowa Code section 249A.4 and 2000 Iowa Acts, chapter 1228, section 9.
441—78.48(249A) Public health agencies. Payments will be made to local public health agencies on a fee schedule basis for providing vaccine and vaccine administration and testing for communicable disease. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a public health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[ARC 0358C; IAB 10/3/12, effective 11/7/12]

441—78.49(249A) Infant and toddler program services. Subject to the following subrules, payment shall be made for medical services provided to Medicaid eligible children by infant and toddler program providers under the infants and toddlers with disabilities program administered by the Iowa Child Health Specialty Clinics and the departments of education, public health, and human services.

78.49(1) Covered services. Covered services include, but are not limited to, audiology, psychological evaluation and counseling, health and nursing services, nutrition services, occupational therapy services, physical therapy services, developmental services, speech-language services, vision services, case management, and medical transportation.

78.49(2) Case management services. Payment shall also be approved for infant and toddler case management services subject to the following requirements:

a. Definition. “Case management” means services that will assist eligible children in gaining access to needed medical, social, educational, and other services. Case management is intended to address the complexities of coordinated service delivery for children with medical needs. The case manager should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need. Case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible child has been referred or any activities that are an integral part or an extension of the direct services.

b. Choice of provider. Children who also are eligible to receive targeted case management services under 441—Chapter 90 must choose whether to receive case management through the infant and toddler program or through 441—Chapter 90. The chosen provider must meet the requirements of this subrule.

(1) When a child resides in a medical institution, the institution is responsible for case management. The child is not eligible for any other case management services. However, noninstitutional case management services may be provided during the last 14 days before the child’s planned discharge if the child’s stay in the institution has been less than 180 consecutive days. If the child has been in the institution 180 consecutive days or longer, the child may receive noninstitutional case management services during the last 60 days before the child’s planned discharge.

(2) If the case management agency also provides direct services, the case management unit must be designed so that conflict of interest is addressed and does not result in self-referrals.

(3) If the costs of any part of case management services are reimbursable under another program, the costs must be allocated between those programs and Medicaid in accordance with OMB Circular No. A-87 or any related or successor guidance or regulations regarding allocation of costs.

(4) The case manager must complete a competency-based training program with content related to knowledge and understanding of eligible children, Early ACCESS rules, the nature and scope of services in Early ACCESS, and the system of payments for services, as well as case management responsibilities and strategies. The department of education or its designee shall determine whether a person has successfully completed the training.

c. Assessment. The case manager shall conduct a comprehensive assessment and periodic reassessment of an eligible child to identify all of the child’s service needs, including the need for any medical, educational, social, or other services. Assessment activities are defined to include the following:

(1) Taking the child’s history;

(2) Identifying the needs of the child;

(3) Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the child;
(4) Completing documentation of the information gathered and the assessment results; and
(5) Repeating the assessment every six months to determine whether the child’s needs or preferences have changed.

d. Plan of care. The case manager shall develop a plan of care based on the information collected through the assessment or reassessment. The plan of care shall:
   (1) Include the child’s strengths and preferences;
   (2) Consider the child’s physical and social environment;
   (3) Specify goals of providing services to the child; and
   (4) Specify actions to address the child’s medical, social, educational, and other service needs. These actions may include activities such as ensuring the active participation of the child and working with the child or the child’s authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the child.

e. Other service components. Case management must include the following components:
   (1) Contacts with the child and family. The case manager shall have face-to-face contact with the child and family within the first 30 days of service and every three months thereafter. In months in which there is no face-to-face contact, a telephone contact between the service coordinator and the family is required.
   (2) Referral and related activities to help a child obtain needed services. The case manager shall help to link the child with medical, social, or educational providers or other programs and services that are capable of providing needed services. Referral activities do not include provision of the direct services, program, or activity to which the child has been linked. Referral activities include:
      1. Assisting the family in gaining access to the infant and toddler program services and other services identified in the child’s plan of care.
      2. Assisting the family in identifying available service providers and funding resources and documenting unmet needs and gaps in services.
      3. Making referrals to providers for needed services.
      4. Scheduling appointments for the child.
      5. Facilitating the timely delivery of services.
      6. Arranging payment for medical transportation.
   (3) Monitoring and follow-up activities. Monitoring activities shall take place at least once annually for the duration of the child’s eligibility, but may be conducted as frequently as necessary to ensure that the plan of care is effectively implemented and adequately addresses the needs of the child. Monitoring and follow-up activities may be with the child, family members, providers, or other entities. The purpose of these activities is to help determine:
      1. Whether services are being furnished in accordance with the child’s plan of care.
      2. Whether the services in the plan of care are adequate to meet the needs of the child.
      3. Whether there are changes in the needs or status of the child. If there are changes in the child’s needs or status, follow-up activities shall include making necessary adjustments to the plan of care and to service arrangements with providers.
      (4) Keeping records, including preparing reports, updating the plan of care, making notes about plan activities in the child’s record, and preparing and responding to correspondence with the family and others.

f. Documentation of case management. For each child receiving case management, case records must document:
   (1) The name of the child;
   (2) The dates of case management services;
   (3) The agency chosen by the family to provide the case management services;
   (4) The nature, content, and units of case management services received;
   (5) Whether the goals specified in the care plan have been achieved;
   (6) Whether the family has declined services in the care plan;
   (7) Time lines for providing services and reassessment; and
   (8) The need for and occurrences of coordination with case managers of other programs.
78.49(3) Child’s eligibility. Payable services must be provided to a child under the age of 36 months who is experiencing developmental delay or who has a condition that is known to have a high probability of resulting in developmental delay at a later date.

78.49(4) Delivery of services. Services must be delivered directly by the infant and toddler program provider or by a practitioner under contract with the infant and toddler program provider.

78.49(5) Remission of nonfederal share of costs. Payment for services shall be made only when the following conditions are met:
   a. Rescinded IAB 5/10/06, effective 7/1/06.
   b. The infant and toddler program provider has executed an agreement to remit the nonfederal share of the cost to the department.
   c. The infant and toddler program provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services specified on the form.

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

441—78.50(249A) Local education agency services. Subject to the following subrules, payment shall be made for medical services provided by local education agency services providers to Medicaid members under the age of 21.

78.50(1) Covered services. Covered services include, but are not limited to, audiology services, behavior services, consultation services, medical transportation, nursing services, nutrition services, occupational therapy services, personal assistance, physical therapy services, psychologist services, speech-language services, social work services, vision services, and school-based clinic visit services.
   a. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a local education agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.
   b. Payment for supplies shall be approved when the supplies are incidental to the patient’s care, e.g., syringes for injections, and do not exceed $25 per month. Durable medical equipment and other supplies are not covered as local education agency services.
   c. To the extent that federal funding is not available under Title XIX of the Social Security Act, payment for transportation between home and school is not a covered service.

78.50(2) Coordination services. Rescinded IAB 12/3/08, effective 2/1/09.

78.50(3) Delivery of services. Services must be delivered directly by the local education agency services providers or by a practitioner under contract with the local education agency services provider.

78.50(4) Remission of nonfederal share of costs. Payment for services shall be made only when the following conditions are met:
   a. Rescinded IAB 5/10/06, effective 7/1/06.
   b. The local education agency services provider has executed an agreement to remit the nonfederal share of the cost to the department.
   c. The local education agency provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services as specified on the form.

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

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

441—78.51(249A) Indian health service 638 facility services. Payment shall be made for all medically necessary services and supplies provided by a licensed practitioner at an Indian health service 638 facility, as defined at rule 441—77.45(249A), within the practitioner’s scope of practice and subject to the limitations and exclusions set forth in subrule 78.1(1).

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

441—78.52(249A) HCBS children’s mental health waiver services. Payment will be approved for the following services to members eligible for the HCBS children’s mental health waiver as established
in 441—Chapter 83 and as identified in the member’s service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.52(1) General service standards. All children’s mental health waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member’s service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

1. Any restrictions on the member’s rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

2. The need for the restriction.

3. The less intrusive methods of meeting the need that have been tried but did not work.

4. Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

5. Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

6. The informed consent of the member.

7. An assurance that the interventions and supports will cause no harm to the member.

8. A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

1. Add together the minutes spent on all billable activities during a calendar day for a daily total.

2. For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

3. Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

4. Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

78.52(2) Environmental modifications and adaptive devices.

a. Environmental modifications and adaptive devices include medically necessary items installed or used within the member’s home that are used by the member to address specific, documented health, mental health, or safety concerns. The following items are excluded under this service:

1. Items ordinarily covered by Medicaid.

2. Items funded by educational or vocational rehabilitation programs.

3. Items provided by voluntary means.

4. Repair and maintenance of items purchased through the waiver.

5. Fencing.

b. A unit of service is one modification or device.

c. For each unit of service provided, the case manager shall maintain in the member’s case file a signed statement from a mental health professional on the member’s interdisciplinary team that the service has a direct relationship to the member’s diagnosis of serious emotional disturbance.

d. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.52(3) Family and community support services. Family and community support services shall support the member and the member’s family by the development and implementation of strategies and
interventions that will result in the reduction of stress and depression and will increase the member’s and the family’s social and emotional strength.

a. Dependent on the needs of the member and the member’s family members individually or collectively, family and community support services may be provided to the member, to the member’s family members, or to the member and the family members as a family unit.

b. Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the member’s interdisciplinary team pursuant to 441—Chapter 83.

c. Family and community support services shall incorporate recommended support interventions and activities, which may include the following:

1. Developing and maintaining a crisis support network for the member and for the member’s family.
2. Modeling and coaching effective coping strategies for the member’s family members.
3. Building resilience to the stigma of serious emotional disturbance for the member and the family.
4. Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.
5. Modeling and coaching the strategies and interventions identified in the member’s crisis intervention plan as defined in 441—24.1(225C) for life situations with the member’s family and in the community.
6. Developing medication management skills.
7. Developing personal hygiene and grooming skills that contribute to the member’s positive self-image.
8. Developing positive socialization and citizenship skills.

d. Family and community support services may include an amount not to exceed $1500 per member per year for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

1. The interdisciplinary team must have identified the transportation or therapeutic resource as a support need and included that need in the case manager’s plan.
2. The annual amount available for transportation and therapeutic resources must be listed in the member’s service plan.
3. The member’s parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the member or the member’s family or legal guardian.
4. The member’s Medicaid case manager shall maintain a signed statement that potential community resources are unavailable and shall list the community resources contacted to fund the transportation or therapeutic resource.
5. The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

e. The following components are specifically excluded from family and community support services:

1. Vocational services.
2. Prevocational services.
3. Supported employment services.
4. Room and board.
5. Academic services.

f. A unit of family and community support services is 15 minutes.

78.52(4) In-home family therapy. In-home family therapy provides skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment.
a. The goal of in-home family therapy is to maintain a cohesive family unit.

b. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through the Iowa Plan or other funding sources.

c. A unit of in-home family therapy service is 15 minutes.

78.52(5) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member’s current living situation.

a. Respite services provided outside the member’s home shall not be reimbursable if the living unit where respite care is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member’s interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child’s day care.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more members who require nursing care because of a mental or physical condition must be provided by a health care facility licensed under Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 3874C, IAB 7/4/18, effective 8/8/18]

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 a standardized comprehensive functional neurobehavioral assessment reviewed or completed by a licensed neuropsychologist, neurologist, M.D., or D.O. The neurobehavioral assessment shall document the member’s need for community-based neurobehavioral rehabilitation, and the medical services unit of the Iowa Medicaid enterprise has determined that the member is in need of specialty neurobehavioral rehabilitation services.

e. Standards for assessment. Each member will have had a department-approved, standardized comprehensive functional neurobehavioral assessment completed within the 90 days prior to admission. Each needs assessment will include the assessment of a member’s individual physical, emotional, cognitive, medical and psychosocial residuals related to the member’s brain injury, which 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).

(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]

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.
   8. Date of last episode of acute recurrence of illness or symptoms.
(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.

[ARC 3551C, IAB 1/3/18, effective 2/7/18]

[Filed 3/11/70; amended 3/20/74]

[Filed 11/25/75, Notice 10/6/75—published 12/15/75, effective 1/19/76]

[Filed emergency 12/23/75—published 1/12/76, effective 2/1/76]

[Filed emergency 1/16/76—published 2/9/76, effective 2/1/76]

[Filed emergency 1/29/76—published 2/9/76, effective 1/29/76]

[Filed 4/30/76, Notice 3/22/76—published 5/17/76, effective 6/21/76]

[Filed emergency 6/9/76—published 6/28/76, effective 6/9/76]

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

[Filed emergency 12/17/76—published 1/12/77, effective 1/1/77]

[Filed 2/25/77, Notice 1/12/77—published 3/23/77, effective 4/27/77]

[Filed emergency 4/13/77—published 5/4/77, effective 4/13/77]

[Filed emergency 7/20/77—published 8/10/77, effective 7/20/77]

[Filed emergency 8/24/77—published 9/21/77, effective 8/26/77]

[Filed emergency 9/1/77—published 9/21/77, effective 9/1/77]

[Filed 11/22/77, Notice 9/7/77—published 12/14/77, effective 2/1/78]

[Filed 12/6/77, Notice 10/19/77—published 12/28/77, effective 2/1/78]
[Filed 1/16/78, Notice 11/30/77—published 2/8/78, effective 4/1/78]
[Filed 3/27/78, Notice 2/8/78—published 4/19/78, effective 5/24/78]
[Filed without Notice 3/31/78—published 4/19/78, effective 7/1/78]
[Filed emergency 6/9/78—published 6/28/78, effective 7/5/78]
[Filed emergency 6/28/78—published 7/26/78, effective 7/1/78]
[Filed 8/9/78, Notice 6/28/78—published 9/6/78, effective 10/11/78]
[Filed 8/18/78, Notice 5/31/78—published 9/6/78, effective 10/11/78]
[Filed 9/12/78, Notice 4/19/78—published 10/4/78, effective 11/8/78]
[Filed 9/12/78, Notice 7/26/78—published 10/4/78, effective 12/1/78]
[Filed 11/20/78, Notice 10/4/78—published 12/13/78, effective 1/17/79]
[Filed 12/6/78, Notice 10/4/78—published 12/27/78, effective 2/1/79]
[Filed 12/6/78, Notice 5/31/78—published 12/27/78, effective 2/1/79]
[Filed emergency 1/31/79—published 2/21/79, effective 3/8/79]
[Filed emergency 6/26/79—published 7/25/79, effective 7/1/79]
[Filed 10/24/79, Notice 5/30/79—published 11/14/79, effective 12/19/79]
[Filed 10/24/79, Notice 8/22/79—published 11/14/79, effective 12/19/79]
[Filed emergency 1/23/80—published 2/20/80, effective 1/23/80]
[Filed emergency 6/30/80—published 7/23/80, effective 7/1/80]
[Filed emergency 7/3/80—published 7/23/80, effective 7/8/80 to 1/1/81]
[Filed 7/3/80, Notice 4/14/80—published 7/23/80, effective 8/27/80]
[Filed 9/25/80, Notice 8/6/80—published 10/15/80, effective 11/19/80]
[Filed without Notice 9/26/80—published 10/15/80, effective 12/1/80]
[Filed 10/23/80, Notice 7/23/80—published 11/12/80, effective 12/17/80]
[Filed 11/21/80, Notice 9/3/80—published 12/10/80, effective 1/14/81]
[Filed 12/19/80, Notices 10/15/80, 10/29/80—published 1/7/81, effective 2/11/81]
[Filed emergency 1/20/81—published 2/18/81, effective 1/20/81]
[Filed 2/12/81, Notice 11/12/80—published 3/4/81, effective 7/1/81]
[Filed 3/24/81, Notice 2/4/81—published 4/15/81, effective 6/1/81]
[Filed emergency 6/30/81—published 7/22/81, effective 7/1/81]
[Filed emergency 8/24/81 after Notice 7/8/81—published 9/16/81, effective 9/1/81]
[Filed 10/23/81, Notice 9/2/81—published 11/11/81, effective 1/1/82]
[Filed emergency 12/3/81—published 12/23/81, effective 1/1/82]
[Filed 1/28/82, Notice 10/28/81—published 2/17/82, effective 4/1/82]
[Filed 1/28/82, Notice 11/25/81—published 2/17/82, effective 4/1/82]
[Filed 2/26/82, Notice 10/14/81—published 3/17/82, effective 5/1/82]
[Filed emergency 3/26/82—published 4/14/82, effective 4/1/82]
[Filed 4/5/82, Notice 1/20/82—published 4/28/82, effective 6/2/82]
[Filed 4/29/82, Notice 12/9/81—published 5/26/82, effective 7/1/82]
[Filed 7/30/82, Notices 3/3/82, 4/28/82—published 8/18/82, effective 10/1/82]
[Filed emergency 9/23/82 after Notice 6/23/82—published 10/13/82, effective 10/1/82]
[Filed 11/5/82, Notice 9/15/82—published 11/24/82, effective 1/1/83]
[Filed 2/25/83, Notice 1/5/83—published 3/16/83, effective 5/1/83]
[Filed 5/20/83, Notices 3/30/83, 4/13/83—published 6/8/83, effective 8/1/83]  
[Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]
[Filed emergency 7/29/83—published 8/17/83, effective 8/1/83]  
[Filed 7/29/83, Notice 5/25/83—published 8/17/83, effective 10/1/83]
[Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]
[Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]
[Filed 10/28/83, Notices 8/31/83, 9/14/83—published 11/23/83, effective 1/1/84]
[Filed emergency 11/18/83—published 12/7/83, effective 12/1/83]
[Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
[Filed 5/4/84, Notice 3/14/84—published 5/23/84, effective 7/1/84]
[Filed emergency 6/15/84—published 7/4/84, effective 7/1/84]
[Filed 6/15/84, Notice 5/9/84—published 7/4/84, effective 9/1/84]
[Filed emergency 8/31/84—published 9/26/84, effective 10/1/84]
[Filed 11/1/84, Notice 9/12/84—published 11/21/84, effective 1/1/85]
[Filed 12/11/84, Notice 10/10/84—published 1/2/85, effective 3/1/85]
[Filed 1/21/85, Notice 10/24/84—published 2/13/85, effective 4/1/85]
[Filed 4/29/85, Notice 12/19/84—published 5/22/85, effective 7/1/85]
[Filed 4/29/85, Notice 2/27/85—published 5/22/85, effective 7/1/85]
[Filed 5/29/85, Notice 3/27/85—published 6/19/85, effective 8/1/85]
[Filed emergency 8/23/85—published 9/11/85, effective 9/1/85]
[Filed emergency 10/1/85—published 10/23/85, effective 11/1/85]
[Filed without Notice 10/1/85—published 10/23/85, effective 12/1/85]
[Filed emergency 10/18/85 after Notice 9/11/85—published 11/6/85, effective 11/1/85]
[Filed 11/15/85, Notice 9/25/85—published 12/4/85, effective 2/1/86]
[Filed emergency 12/2/85—published 12/18/85, effective 1/1/86]
[Filed 12/2/85, Notice 10/23/85—published 12/18/85, effective 2/1/86]
[Filed 1/22/86, Notice 12/4/85—published 2/12/86, effective 4/1/86]
[Filed 2/21/86, Notices 12/18/85, 1/1/86, 1/15/86—published 3/12/86, effective 5/1/86]
[Filed emergency 6/26/86—published 7/16/86, effective 7/1/86]
[Filed 9/26/86, Notice 8/13/86—published 10/22/86, effective 12/1/86]
[Filed emergency 12/22/86—published 1/14/87, effective 2/1/87]
[Filed 12/22/86, Notice 11/5/86—published 1/14/87, effective 3/1/87]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed 3/3/87, Notices 12/17/86, 12/31/86, 1/14/87—published 3/25/87, effective 5/1/87]
[Filed 4/29/87, Notice 3/11/87—published 5/20/87, effective 7/1/87]
[Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]
[Filed 6/19/87, Notice 5/6/87—published 7/15/87, effective 9/1/87]
[Filed 7/24/87, Notice 5/20/87—published 8/12/87, effective 10/1/87]
[Filed emergency 8/28/87—published 9/23/87, effective 9/1/87]
[Filed 9/24/87, Notice 8/12/87—published 10/21/87, effective 12/1/87]
[Filed 12/10/87, Notice 10/21/87—published 12/30/87, effective 3/1/88]
[Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]
[Filed emergency 11/16/88 after Notice 10/5/88—published 12/14/88, effective 1/1/89]
[Filed 12/8/88, Notice 10/19/88—published 12/28/88, effective 2/1/89]
[Filed 3/15/89, Notice 2/8/89—published 4/5/89, effective 6/1/89]
[Filed emergency 6/8/89 after Notice 2/22/89—published 6/28/89, effective 7/1/89]
[Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
[Filed 7/14/89, Notices 4/19/89, 5/31/89—published 8/9/89, effective 10/1/89]
[Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
[Filed 9/15/89, Notice 8/9/89—published 10/4/89, effective 12/1/89]
[Filed 10/11/89, Notice 8/23/89—published 11/1/89, effective 1/1/90]
[Filed 11/16/89, Notice 8/23/89—published 12/13/89, effective 2/1/90]
[Filed emergency 12/15/89 after Notice 10/4/89—published 1/10/90, effective 1/1/90]
[Filed 1/17/90, Notice 8/23/89—published 2/7/90, effective 4/1/90]  
[Filed emergency 2/14/90—published 3/7/90, effective 2/14/90]
[Filed 3/16/90, Notices 11/15/89, 1/24/90, 2/7/90—published 4/4/90, effective 6/1/90]
[Filed 4/13/90, Notice 3/7/90—published 5/2/90, effective 7/1/90]
[Filed 4/13/90, Notice 11/29/89—published 5/2/90, effective 8/1/90]
[Filed emergency 6/20/90—published 7/11/90, effective 7/1/90]
[Filed 7/13/90, Notices 5/16/90, 5/30/90—published 8/8/90, effective 10/1/90]
[Filed 8/16/90, Notice 7/11/90—published 9/5/90, effective 11/1/90]
[Filed 9/28/90, Notices 7/11/90, 7/25/90, 8/8/90—published 10/17/90, effective 12/1/90]
[Filed 10/12/90, Notice 7/11/90—published 10/31/90, effective 1/1/91]
[Filed 10/12/90, Notice 8/8/90—published 10/31/90, effective 2/1/91]
[Filed 11/16/90, Notices 9/19/90, 10/3/90—published 12/12/90, effective 2/1/91]
[Filed 12/13/90, Notice 10/31/90—published 1/9/91, effective 3/1/91]
[Filed emergency 1/17/91—published 2/6/91, effective 2/1/91]
[Filed 1/17/91, Notices 11/14/90, 11/28/90—published 2/6/91, effective 4/1/91]  
[Filed emergency 2/22/91—published 3/20/91, effective 3/1/91]
[Filed 3/14/91, Notice 2/6/91—published 4/3/91, effective 6/1/91]
[Filed 4/11/91, Notice 3/6/91—published 5/1/91, effective 7/1/91]
[Filed emergency 6/14/91—published 7/10/91, effective 7/1/91]
[Filed 6/14/91, Notice 3/20/91—published 7/10/91, effective 9/1/91]
[Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]
[Filed 9/18/91, Notices 7/10/91, 7/24/91—published 10/16/91, effective 12/1/91]
[Filed 12/11/91, Notice 10/16/91—published 1/8/92, effective 3/1/92]
[Filed 12/11/91, Notice 10/30/91—published 1/8/92, effective 3/1/92]
[Filed emergency 1/16/92 after Notice 11/27/91—published 2/5/92, effective 3/1/92]  
[Filed 2/13/92, Notice 1/8/92—published 3/4/92, effective 5/1/92]
[Filed emergency 4/15/92—published 5/13/92, effective 4/16/92]
[Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]
[Filed 6/11/92, Notices 3/18/92, 4/29/92—published 7/8/92, effective 9/1/92]
[Filed emergency 7/17/92—published 8/5/92, effective 8/1/92]
[Filed 7/17/92, Notices 5/27/92—published 8/5/92, effective 10/1/92]  
[Filed emergency 8/14/92—published 9/2/92, effective 9/1/92]
[Filed 8/14/92, Notices 6/24/92, 7/8/92, 8/5/92—published 9/2/92, effective 11/1/92]
[Filed emergency 9/11/92—published 9/30/92, effective 10/1/92]
[Filed 9/11/92, Notices 7/8/92, 8/5/92—published 9/30/92, effective 12/1/92]
[Filed 9/11/92, Notice 8/5/92—published 9/30/92, effective 1/1/93]
[Filed 10/15/92, Notices 8/19/92, 9/2/92—published 11/11/92, effective 1/1/93]
[Filed emergency 11/10/92—published 12/9/92, effective 11/10/92]
[Filed 11/10/92, Notice 9/30/92—published 12/9/92, effective 2/1/93]
[Filed 1/14/93, Notices 10/28/92, 11/25/92—published 2/3/93, effective 4/1/93]
[Filed emergency 4/15/93 after Notice 3/3/93—published 5/12/93, effective 5/1/93]
[Filed 4/15/93, Notice 3/3/93—published 5/12/93, effective 7/1/93]
[Filed emergency 5/14/93 after Notice 3/31/93—published 6/9/93, effective 6/1/93]
[Filed 5/14/93, Notice 3/31/93—published 6/9/93, effective 8/1/93]
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[Filed emergency 12/16/93 after Notice 10/13/93—published 1/5/94, effective 1/1/94]
[Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]
[Filed 1/12/94, Notice 11/10/93—published 2/2/94, effective 4/1/94]
[Filed emergency 2/10/94 after Notice 12/22/93—published 3/2/94, effective 3/1/94]
[Filed 3/10/94, Notice 2/2/94—published 3/30/94, effective 6/1/94]
[Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]
[Filed 8/12/94, Notice 6/22/94—published 8/31/94, effective 11/1/94]
[Filed 11/9/94, Notice 9/14/94—published 12/7/94, effective 2/1/95]
[Filed 5/11/95, Notices 3/29/95—published 6/7/95, effective 8/1/95]
[Filed 6/7/95, Notice 4/26/95—published 7/5/95, effective 9/1/95]
[Filed 6/14/95, Notice 5/10/95—published 7/5/95, effective 9/1/95]
[Filed 10/12/95, Notice 8/30/95—published 11/8/95, effective 1/1/96]
[Filed 11/16/95, Notices 8/2/95, 9/27/95—published 12/6/95, effective 2/1/96]
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[Filed 4/12/00, Notice 2/23/00—published 5/3/00, effective 7/1/00]
[Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
[Filed 6/8/00, Notice 4/19/00—published 6/28/00, effective 8/2/00]
[Filed 6/8/00, Notices 1/26/00, 4/19/00—published 6/28/00, effective 9/1/00]
[Filed 8/9/00, Notices 6/14/00, 6/28/00—published 9/6/00, effective 11/1/00]
[Filed emergency 9/12/00 after Notice 7/26/00—published 10/4/00, effective 10/1/00]
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[Filed emergency 12/14/00 after Notice 9/20/00—published 1/10/01, effective 1/1/01]
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[Filed emergency 6/13/01 after Notice 4/18/01—published 7/11/01, effective 7/1/01]
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[Filed 11/14/01, Notices 9/19/01, 10/3/01—published 12/12/01, effective 2/1/02]
[Filed emergency 12/12/01 after Notice 10/17/01—published 1/9/02, effective 12/12/01]
[Filed 12/12/01, Notice 7/11/01—published 1/9/02, effective 3/1/02]
[Filed 12/12/01, Notice 10/17/01—published 1/9/02, effective 3/1/02]
[Filed emergency 1/9/02 after Notice 11/14/01—published 2/6/02, effective 2/1/02]
[Filed emergency 1/16/02—published 2/6/02, effective 2/1/02]
[Filed emergency 2/14/02—published 3/6/02, effective 3/1/02]
[Filed 3/13/02, Notice 1/9/02—published 4/3/02, effective 6/1/02]
[Filed 3/13/02, Notice 1/23/02—published 4/3/02, effective 6/1/02]
[Filed emergency 4/12/02—published 5/1/02, effective 4/12/02]
[Filed 4/10/02, Notice 1/9/02—published 5/1/02, effective 7/1/02]
[Filed 4/10/02, Notice 3/6/02—published 5/1/02, effective 7/1/02]
[Filed emergency 7/11/02—published 8/7/02, effective 7/11/02]
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[Filed emergency 11/18/02—published 12/11/02, effective 12/1/02]
[Filed emergency 11/18/02—published 12/11/02, effective 12/15/02]
[Filed 11/18/02, Notice 9/4/02—published 12/11/02, effective 2/1/03]
[Filed emergency 12/12/02 after Notice 10/16/02—published 1/8/03, effective 1/1/03]
[Filed 12/12/02, Notice 10/30/02—published 1/8/03, effective 3/1/03]
[Filed emergency 1/9/03—published 2/5/03, effective 2/1/03]
[Filed 2/13/03, Notice 11/27/02—published 3/5/03, effective 5/1/03]
[Filed 2/13/03, Notice 12/11/02—published 3/5/03, effective 5/1/03]
[Filed emergency 6/12/03—published 7/9/03, effective 7/1/03]
[Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]
[Filed emergency 11/19/03—published 12/10/03, effective 1/1/04]
[Filed 1/16/04, Notices 9/17/03, 10/29/03—published 2/4/04, effective 3/10/04]
[Filed 3/11/04, Notice 1/21/04—published 3/31/04, effective 6/1/04]
[Filed emergency 6/14/04 after Notice 4/28/04—published 7/7/04, effective 7/1/04]
[Filed 8/12/04, Notice 6/23/04—published 9/1/04, effective 11/1/04]
[Filed emergency 4/15/05—published 5/11/05, effective 5/1/05]
[Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
[Filed 7/15/05, Notice 5/25/05—published 8/3/05, effective 10/1/05]
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[Filed 10/21/05, Notices 5/11/05 and 7/6/05—published 11/9/05, effective 12/14/05]
[Filed 10/21/05, Notice 8/31/05—published 11/9/05, effective 1/1/06]
[Filed 1/12/06, Notice 11/9/05—published 2/1/06, effective 3/8/06]
[Filed 3/10/06, Notice 10/12/05—published 3/29/06, effective 5/3/06]
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[Filed emergency 10/12/06 after Notice 8/30/06—published 11/8/06, effective 11/1/06]
[Filed 10/20/06, Notice 8/2/06—published 11/8/06, effective 1/1/07]
[Filed emergency 12/13/06—published 1/3/07, effective 1/1/07]
[Filed emergency 3/14/07 after Notice 1/3/07—published 4/11/07, effective 4/1/07]
[Filed emergency 3/14/07 after Notice 1/17/07—published 4/11/07, effective 4/1/07]
[Filed 3/14/07, Notice 10/11/06—published 4/11/07, effective 5/16/07]
[Filed emergency 7/12/07—published 8/1/07, effective 7/12/07]
[Filed emergency 7/12/07 after Notice 5/23/07—published 8/1/07, effective 8/1/07]
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[Filed emergency 9/12/07 after Notice 7/18/07—published 10/10/07, effective 10/1/07]
[Filed emergency 1/9/08 after Notice 10/10/07—published 1/30/08, effective 2/1/08]
[Filed 1/9/08, Notice 11/7/07—published 1/30/08, effective 4/1/08]
[Filed emergency 5/14/08 after Notice 3/26/08—published 6/4/08, effective 5/15/08]
[Filed emergency 5/14/08 after Notice 3/26/08—published 6/4/08, effective 6/1/08]
[Filed emergency 6/11/08 after Notice 3/12/08—published 7/2/08, effective 7/1/08]
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[Filed 11/12/08, Notice 9/24/08—published 12/3/08, effective 2/1/09]
[Filed 12/11/08, Notice 9/10/08—published 1/14/09, effective 2/18/09]
[Filed 12/11/08, Notice 10/22/08—published 1/14/09, effective 3/1/09]
[Filed ARC 7548B (Notice ARC 7369B, IAB 11/19/08), IAB 2/11/09, effective 4/1/09]
[Filed Emergency After Notice ARC 7957B (Notice ARC 7631B, IAB 3/11/09; Amended Notice ARC 7732B, IAB 4/22/09), IAB 7/15/09, effective 7/1/09]
[Filed Emergency After Notice ARC 8008B (Notice ARC 7771B, IAB 5/20/09), IAB 7/29/09, effective 8/1/09]
[Filed ARC 8097B (Notice ARC 7816B, IAB 6/3/09), IAB 9/9/09, effective 11/1/09]
[Filed ARC 8205B (Notice ARC 7827B, IAB 6/3/09), IAB 10/7/09, effective 11/1/09]
[Filed Emergency ARC 8344B, IAB 12/2/09, effective 12/1/09]
[Filed ARC 8504B (Notice ARC 8247B, IAB 10/21/09), IAB 2/10/10, effective 3/22/10]
[Filed Emergency After Notice ARC 8643B (Notice ARC 8345B, IAB 12/2/09), IAB 4/7/10, effective 3/11/10]
[Filed Emergency After Notice ARC 8714B (Notice ARC 8538B, IAB 2/24/10), IAB 5/5/10, effective 5/1/10]
[Filed ARC 8993B (Notice ARC 8722B, IAB 5/5/10), IAB 8/11/10, effective 10/1/10]
[Filed ARC 8994B (Notice ARC 8756B, IAB 5/19/10), IAB 8/11/10, effective 10/1/10]
[Filed ARC 9045B (Notice ARC 8832B, IAB 6/2/10), IAB 9/8/10, effective 11/1/10]
[Filed Emergency ARC 9132B, IAB 10/6/10, effective 11/1/10]
[Filed ARC 9175B (Notice ARC 8975B, IAB 7/28/10), IAB 11/3/10, effective 1/1/11]
[Filed Emergency ARC 9256B, IAB 12/1/10, effective 1/1/11]
[Filed Emergency ARC 9311B, IAB 12/29/10, effective 1/1/11]
[Filed ARC 9315B (Notice ARC 9111B, IAB 10/6/10), IAB 12/29/10, effective 2/2/11]
[Filed ARC 9316B (Notice ARC 9133B, IAB 10/6/10), IAB 12/29/10, effective 2/2/11]
[Filed ARC 9403B (Notice ARC 9170B, IAB 10/20/10), IAB 3/9/11, effective 5/1/11]
[Filed Emergency After Notice ARC 9440B (Notice ARC 9276B, IAB 12/15/10), IAB 4/6/11, effective 4/1/11]
[Editorial change: IAC Supplement 4/20/11]
[Filed ARC 9487B (Notice ARC 9399B, IAB 2/23/11), IAB 5/4/11, effective 7/1/11]
[Filed ARC 9588B (Notice ARC 9367B, IAB 2/9/11; Amended Notice ARC 9448B, IAB 4/6/11), IAB 6/29/11, effective 9/1/11]
[Filed Emergency After Notice ARC 9649B (Notice ARC 9538B, IAB 6/1/11), IAB 8/10/11, effective 8/1/11]
[Filed ARC 9650B (Notice ARC 9497B, IAB 5/4/11), IAB 8/10/11, effective 10/1/11]
[Filed Emergency ARC 9699B, IAB 9/7/11, effective 9/1/11]
[Filed Emergency ARC 9702B, IAB 9/7/11, effective 9/1/11]
[Filed Emergency ARC 9704B, IAB 9/7/11, effective 9/1/11]
[Filed Emergency ARC 9834B, IAB 11/2/11, effective 11/1/11]
[Filed ARC 9882B (Notice ARC 9700B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]
[Filed ARC 9883B (Notice ARC 9703B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]
[Filed ARC 9884B (Notice ARC 9705B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]
[Filed ARC 9981B (Notice ARC 9835B, IAB 11/2/11), IAB 2/8/12, effective 3/14/12]
[Filed ARC 0065C (Notice ARC 9940B, IAB 12/28/11), IAB 4/4/12, effective 6/1/12]
[Filed Emergency ARC 0191C, IAB 7/11/12, effective 7/1/12]
[Filed Emergency ARC 0194C, IAB 7/11/12, effective 7/1/12]
[Filed Emergency After Notice ARC 0198C (Notice ARC 0117C, IAB 5/2/12), IAB 7/11/12, effective 7/1/12]
[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 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]
[Filed ARC 4575C (Notice ARC 4444C, IAB 5/22/19), IAB 7/31/19, effective 9/4/19]

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.
CHAPTER 97
COLLECTION SERVICES CENTER

PREAMBLE

The collection services center is the public agency designated by state law as the state disbursement unit with responsibility for the receipt, recording and disbursement of specified support payments within the state of Iowa. The administrative guidelines within this chapter describe the process of transferring support cases or information from the clerks of district court to the collection services center and the policies and procedures used to receive, monitor, and distribute support payments.

441—97.1(252B) Definitions. The definitions of terms used in this chapter shall follow those terms defined in rule 441—95.1(252B) with the exception or addition of the following:

“Collection services center” means the public agency designated to receive, record, monitor, and disburse support payments as defined in Iowa Code section 598.1, 252B.15 or 252D.16, in accordance with Iowa Code sections 252B.13A and 252B.14.

“Correlated non-IV-D case” means a non-IV-D case where income withholding information must be maintained by the unit in order to properly process an income withholding payment because the obligor has both a non-IV-D and a current or former IV-D case.

“Electronic funds transmission” means, for purposes of this chapter, the use of a NACHA-approved child support format for the electronic transmission of funds to the collection services center.

“Employee” shall have the same meaning provided this term in Iowa Code section 252G.1.

“Former IV-D case” means a case that previously received services from the unit under rule 441—95.2(252B) but currently receives only payment processing services from the collection services center.

“Insufficient funds payment” means a support payment by check or other financial instrument which is dishonored, not paid, or the funding of the payment is determined to be inadequate.

“IV-D case” means a case that receives services from the unit under rule 441—95.2(252B), including payment processing services from the collection services center.

“NACHA-approved child support format” means a child support payment transmission format approved by the National Automated Clearing House Association (NACHA).

“Non-IV-D case” means a support order that never received services from the unit under rule 441—95.2(252B), but that receives payment processing services from the collection services center for income withholding payments.

“Obligee” means the guardian, custodial parent, person, or entity entitled to receive support payments.

“Obligor” means a parent, relative, or any other person declared to be legally liable for the support of a child or the custodial parent or guardian of the child.

“Payor of income” shall have the same meaning provided this term in Iowa Code section 252D.16.

“Support payment” shall have the same meaning provided this term in Iowa Code section 252D.16.

“Unit” means the child support recovery unit as defined in Iowa Code section 252B.2.

“Web site” means the Web site operated by the department of human services for the purpose of allowing a payor of income to make a support payment through electronic transmission to the collection services center.

[ARC 9351B, IAB 2/9/11, effective 4/1/11]

441—97.2(252B) Transfer of records and payments. For non-IV-D cases, the clerk of court shall provide core case information to the unit upon the filing of a new income withholding order or upon the request of the unit. “Core case information” means information listed in paragraphs 97.2(1)”a” and “b” and subrule 97.2(2). For IV-D and correlated non-IV-D cases, the clerk of court shall provide detailed case information to the unit upon request. After the establishment of a case, the unit shall send notices of transfer to obligors, obligees, and payors of income based upon case type.

97.2(1) Transfer of information on non-IV-D and correlated non-IV-D cases.
a. In non-IV-D cases, the unit shall request the following information necessary for the receipt, recording and disbursement of payments from the clerk of the district court:
   (1) The obligor’s name and address.
   (2) The obligee’s name and address.
   (3) The court order numbers.
   b. In correlated non-IV-D cases, the unit shall request the following information necessary for the receipt, recording and disbursement of payments from the clerk of the district court:
      (1) The obligor’s name and address.
      (2) The obligee’s name and address.
      (3) The court order numbers.
      (4) The income withholding order.
   c. The clerk of the district court shall provide case information to the unit on a regular basis when an income withholding order is filed with a clerk of court or when the unit requests the information in order to process a payment.
   d. The unit shall automatically create cases for payment processing based upon the information received from the clerks of court.

97.2(2) Transfer of information on IV-D cases. In IV-D cases, the clerk of district court shall provide the unit with the following information if the information has been provided to the clerk upon request of the unit:
   a. The obligee’s name, date of birth, last-known mailing address, the social security number if known and, if different in whole or part, the names of the persons to whom the obligation of support is owed by the obligor.
   b. The name, birth date, social security number, and last-known mailing address of the obligor.
   c. A copy of all support orders that establish or modify a support amount.
   d. The names, social security numbers, and dates of birth of any minor dependents for whom support is ordered, if available.
   e. A record of any support payments received by the clerk of district court prior to the transfer of case information and any payments received by the collection services center and the date of transfer to the collection services center.
   f. A record of any determination of controlling order under the Uniform Interstate Family Support Act.

441—97.3(252B) Support payment records. Each IV-D, former IV-D and non-IV-D case type shall have an official payment record.

97.3(1) Official records for cases. The official payment records for each case type shall be maintained by a designated entity.
   a. The collection services center shall establish, maintain and certify the official support payment records for IV-D or former IV-D cases.
   b. The clerk of the district court shall establish, maintain and certify the official support payment records for non-IV-D and correlated non-IV-D cases. The collection services center shall establish and maintain records for receipt and disbursement of income withholding payments for these cases, but shall not certify these records as the complete payment record.

97.3(2) Informal conference for payment records. The unit shall provide an informal conference or desk review regarding the contents of any support payment record to the obligor or obligee upon request.
   a. In IV-D or former IV-D cases, the conference shall be available to review the payment record and to answer questions of the obligee or obligor regarding the accuracy of the record.
   b. In non-IV-D and correlated non-IV-D cases, the conference shall be available to review the accuracy of the contents of any record of income withholding payments.

97.3(3) Certified payment records. The unit shall provide certified copies of the official support payment records as defined in paragraph 97.3(1)’a’ in accordance with Iowa Code section 252B.9.

[ARC 1262C, IAB 1/8/14, effective 3/1/14]
**441—97.4(252B) Method of payment.** Payments shall be accepted in specific forms from obligors and payors of income.

**97.4(1) Form of payment.** Except as otherwise provided in this rule and in rule 441—97.5(252D), support payments may be paid in the form of cash, check, bank draft, money order, preauthorized withdrawal of funds, or other financial instrument, and sent by mail to the collection services center, or by electronic transmission of funds.

**97.4(2) Treatment of insufficient funds payments.** The unit shall have a process in place to handle insufficient funds payments.

a. An obligor submitting an insufficient funds support payment to the collection services center shall be required to submit payments by cash, bank draft, or money order for a period of up to 12 months unless waived by the collection services center.

b. A payor of income submitting an insufficient funds support payment to the collection services center shall be required to submit payments through electronic funds transmission, cash, bank draft, or money order for a period of up to 12 months unless waived by the collection services center.

c. Insufficient funds payments shall not be credited to the collection services center account for the obligor or shall be removed from the account if credited before sufficiency was verified. Insufficient funds support payments shall be subject to additional collection by the collection services center for the dishonored amount.

d. The collection services center shall not process additional payments other than cash, bank drafts or money orders from an obligor or payor of income who has previously submitted insufficient funds payments without first verifying the payment. The collection services center shall have a process in place to allow the obligor or the payor of income the opportunity to replace any additional moneys submitted for payment of support before processing in order to avoid additional insufficient funds entries into the official payment records on the affected cases.

**97.4(3) Distribution of payment.** Nonincome withholding support payments received by the collection services center in IV-D, former IV-D, non-IV-D, or correlated non-IV-D cases which are not directed to a specific account or support obligation shall first be applied proportionately to the current support obligation on all cases for the obligor and, secondly, to the support arrearages owed by the obligor.

[ARC 9351B, IAB 2/9/11, effective 4/1/11]

**441—97.5(252D) Electronic transmission of payments.** Payors of income shall electronically transmit to the collection services center the amounts withheld under an income withholding order.

**97.5(1) Thresholds for electronic funds transmission.** A payor of income shall transmit payment through electronic funds transmission if either of the following applies:

a. The payor of income employs 100 or more employees and uses an agent for payroll processing.

b. The payor of income employs 200 or more employees.

**97.5(2) Use of the Web site.** Unless paragraph 97.4(2)“b” applies, a payor of income required to use electronic funds transmission under subrule 97.5(1) may elect to submit payments electronically by using the Web site if the payor of income determines that using electronic funds transmission would cause undue hardship.

**97.5(3) Implementing electronic funds transmission.** A payor of income implementing electronic funds transmission shall complete all the following before the implementation date specified in subrule 97.5(5):

a. Contact the collection services center to obtain file layout and case reconciliation information.

b. Provide to the collection services center:

(1) The contact information for the person responsible for electronic funds transmission for the payor of income or the payor of income’s agent for payroll processing;

(2) The contact information for the person responsible for payroll accounts for the payor of income or the payor of income’s agent for payroll processing;

(3) The name and address of the authorized financial institution from which the payment will be withheld; and
(4) A sample file layout in a NACHA-approved child support format and, if necessary, a test file in a NACHA-approved child support format.
   c. If needed upon review by the collection services center:
      (1) Make corrections to the file layout to meet a NACHA-approved child support format, and
      (2) Provide a corrected copy to the collection services center for review.
   d. Upon approval of the file layout by the collection services center, provide an implementation date before the first submission of payment through electronic funds transmission.

97.5(4) Maintaining information and file format after implementation. A payor of income that has implemented electronic funds transmission shall:
   a. Transmit both payment amounts and detailed information records in accordance with a NACHA-approved child support format.
   b. Advise the collection services center of a payment error within two business days.
   c. Provide the collection services center ten working days’ advance notice when changing between NACHA-approved child support formats.
   d. Correct case number or file problems identified by the collection services center before sending any additional files.

97.5(5) Time frames for implementation. A payor of income shall comply with the following implementation schedule:
   a. A payor of income that employs 1,000 or more employees shall implement electronic funds transmission or begin using the Web site no later than December 31, 2011.
   b. A payor of income that employs between 500 and 999 employees shall implement electronic funds transmission or begin using the Web site no later than December 31, 2012.
   c. A payor of income that employs between 200 and 499 employees shall implement electronic funds transmission or begin using the Web site no later than December 31, 2013.
   d. A payor of income that employs 100 or more employees and uses an agent for payroll processing shall implement electronic funds transmission or begin using the Web site no later than December 31, 2013.

97.5(6) Exemption from electronic transmission. To avoid undue hardship, a payor of income that has fewer than 200 employees or a payor of income that has fewer than 100 employees and uses an agent for payroll processing is exempt from using electronic transmission unless subrule 97.4(2) applies.

[ARC 9351B, IAB 2/9/11, effective 4/1/11]

441—97.6(252B) Authorization of payment. The collection services center must authorize the generation of payments for support paid. The collection services center shall issue payments as follows:

97.6(1) Submittal of information to department of administrative services. In order to disburse payments to the obligee within two working days, the collection services center shall submit information daily to the department of administrative services to issue a warrant or electronic file transfer (EFT) payment to the obligee.

97.6(2) Release of funds. The following workday an electronic transfer of funds shall be sent to the designated account of the obligee or an alternate account to be accessed by the obligee through an electronic access card, or if subrule 97.6(5) applies, a state warrant may be sent by regular mail to the last-known address of the obligee.

97.6(3) Electronic transfer. Obligees who want electronic transfer of support payments to a designated account shall complete Form 470-2612, Authorization for Automatic Deposit, and submit it to the collection services center. Unless subrule 97.6(5) applies, any obligee not using automatic deposit to a designated account shall be issued an electronic access card for receipt of support payments.

97.6(4) Walk-ins. Support payments shall not be hand-delivered to the obligee on a walk-in basis.

97.6(5) Warrants. The collection services center may authorize generation of a warrant if any one of the following conditions applies:
   a. Generation of a warrant is necessary to meet federal requirements to disburse a payment to an obligee within two working days when electronic transfer is not feasible.
b. The obligee has not requested automatic deposit to a designated account of the obligee, and payment is from a source that is nonrecurring or is not expected to continue in a 12-month period.

c. The obligee has not requested automatic deposit to a designated account of the obligee and has asserted in writing on Form 470-3972, Electronic Support Payments, that one of the exemptions listed in this paragraph applies. To claim an exemption, the obligee must return Form 470-3972 to the collection services center within ten days of the date the form was issued. An exemption granted under this paragraph is subject to periodic review by the collection services center. The exemptions available under this paragraph are:

(1) A physical disability imposes a hardship in accessing an electronically transferred payment.
(2) A mental disability imposes a hardship in accessing an electronically transferred payment.
(3) A language barrier imposes a hardship in accessing an electronically transferred payment.
(4) A literacy barrier imposes a hardship in accessing an electronically transferred payment.
(5) The obligee’s home and work addresses are more than 30 miles from an automated teller machine and more than 30 miles from a financial institution where the account funds can be accessed.

d. The representative payee, court appointee, or trustee notifies the collection services center or unit in writing that one of the following applies:

(1) The obligee is under a court-ordered guardianship or conservatorship.
(2) The obligee is involved in other legal proceedings, including bankruptcy, which require payments to be sent to a trustee or other representative payee.

[ARC 4576C, IAB 7/31/19, effective 9/4/19]

441—97.7(252B) Processing misdirected payments. If the collection services center receives a payment for which a corresponding obligee cannot be identified, the collection services center shall contact the person or entity that directed the payment to obtain additional information. Payments inappropriately directed to the collection services center shall be returned to the person or entity sending the payment.

These rules are intended to implement Iowa Code sections 252B.13A through 252B.17 and section 252D.17.

[Filed emergency 3/26/87 after Notice 2/11/87—published 4/22/87, effective 4/1/87]
[Filed 7/14/99, Notice 5/19/99—published 8/11/99, effective 10/1/99]
[Filed without Notice 8/15/02—published 9/4/02, effective 11/1/02]
[Filed emergency 2/13/03 after Notice 9/4/02—published 3/5/03, effective 3/1/03]
[Filed 4/10/03, Notice 2/19/03—published 4/30/03, effective 7/1/03]
[Filed emergency 1/19/07—published 2/14/07, effective 1/20/07]
[Filed ARC 9351B (Notice ARC 9215B, IAB 11/3/10), IAB 2/9/11, effective 4/1/11]
[Filed ARC 1262C (Notice ARC 1045C, IAB 10/2/13), IAB 1/8/14, effective 3/1/14]
[Filed ARC 4576C (Notice ARC 4441C, IAB 5/22/19), IAB 7/31/19, effective 9/4/19]
CHAPTER 98
SUPPORT ENFORCEMENT SERVICES

PREAMBLE
In addition to the enforcement services described in 441—Chapter 95, “Collections,” the child support recovery unit is charged with the responsibility to provide the services delineated in this chapter.

DIVISION I
MEDICAL SUPPORT ENFORCEMENT

441—98.1(252E) Definitions.
“Medical support” means either the provision of health care coverage or the payment of cash medical support. Medical support is not alimony.

“Obligee” means a parent or other natural person legally entitled to receive a support payment on behalf of a child.

“Obligor” means a parent or other natural person legally responsible for the support of a dependent.

[ARC 4112C, IAB 11/7/18, effective 2/15/19]

441—98.2(252E) Provision of services. The child support recovery unit shall provide medical support services to public assistance and nonpublic assistance recipients of child support services. Unless good cause has been established, recipients of public assistance are required to cooperate with the child support recovery unit as a condition of eligibility as prescribed in rule 441—75.14(249A).

[ARC 4112C, IAB 11/7/18, effective 2/15/19]

441—98.3(252E) Establishing medical support. Rescinded ARC 4112C, IAB 11/7/18, effective 2/15/19.

441—98.4(252E) Accessibility of the health benefit plan. Rescinded ARC 4112C, IAB 11/7/18, effective 2/15/19.

441—98.5(252E) Health benefit plan information. The unit shall gather information concerning a health benefit plan.

98.5(1) Information from an employer. The unit shall gather information concerning a health benefit plan an employer may offer an obligor as follows:

a. The unit may send Form 470-0177M, Employment and Health Insurance Questionnaire, whenever a potential employer is identified.

b. The unit shall secure information about health care coverage from a known employer on Form 470-2743, Employer Medical Support Information, when Form 470-3818, National Medical Support Notice, or an order has been forwarded to the employer pursuant to Iowa Code section 252E.4.

98.5(2) Information from an obligor. The unit may secure medical support information from an obligor on Form 470-0413, Obligor Insurance Questionnaire.

98.5(3) Disposition of information. The unit shall provide the information:

a. To the Medicaid agency and to the obligee, when requested, when the dependent is a recipient of Medicaid.

b. To the obligee, when requested, when the dependent is not a recipient of Medicaid.

[ARC 4112C, IAB 11/7/18, effective 2/15/19]

441—98.6(252E) Insurer authorization. When the obligor does not provide to the insurer the signed documents necessary to enroll and process claims for the dependent for whom support is ordered, the insurer is authorized to accept the signature of the obligee or the department’s designee on necessary forms. For purposes of Division I of this chapter, the third-party liability unit is the department’s designee when support is assigned.

441—98.7(252E) Enforcement.
98.7(1) Medical support enforcement. For the purposes of enforcement, medical support may be reduced to a dollar amount and collected through the same remedies available for the collection and enforcement of child support.

98.7(2) Health care coverage.
   a. If an obligor was ordered to provide health care coverage under an order but did not comply with the order, the child support recovery unit may implement the order by forwarding to the employer a copy of the order, an ex parte order as provided in Iowa Code section 252E.4, or Form 470-3818, National Medical Support Notice.
   b. If the child support recovery unit implements an order under this subrule, the unit shall send a notice to the obligor at the last-known address of the obligor by regular mail. The notice shall contain the following information:
      (1) A statement of the obligor’s right to an informal conference.
      (2) The process to request an informal conference.
      (3) The obligor’s right to file a motion to quash with the district court.

98.7(3) Termination of employment. When the child support recovery unit receives information indicating the obligor’s employment has terminated, the unit shall secure the status of the health benefit plan by sending Form 470-3218, Employer Insurance Notification, to the employer.

   If no response is received within 30 days of sending Form 470-3218, the unit shall send a second request on Form 470-3219, Employer Insurance Second Notification, to the employer.

[ARC 4112C, IAB 11/7/18, effective 2/15/19]

441—98.8(252E) Contesting the order. The obligor may contest the enforcement of medical support by means of an informal conference with the child support recovery unit, or by filing a motion to quash.

98.8(1) Motion to quash. Procedures for filing a motion to quash the order are specified under Iowa Code sections 252D.31 and 252E.6A.

98.8(2) Informal conference.
   a. The obligor shall be entitled to only one informal conference for each new employer to which the unit has forwarded Form 470-3818, National Medical Support Notice, or order under Iowa Code section 252E.4 to enforce medical support.
   b. Procedures for the informal conference are as follows:
      (1) The child support recovery unit shall inform the obligor in writing of the right to request an informal conference.
      (2) The obligor may request an informal conference with the child support recovery unit if the obligor believes the enforcement was entered in error.
      (3) The obligor shall request an informal conference in writing, within 15 calendar days from the date of the notice of the right to an informal conference, or at any time if a mistake of fact regarding the identity of the obligor is believed to have been made.
      (4) The child support recovery unit shall schedule an informal conference within 15 calendar days of the receipt of a written request from the obligor or the obligor’s representative.
      (5) The child support recovery unit may conduct the conference in person or by telephone.
      (6) If the obligor fails to attend the conference, only one alternative time shall be scheduled by the child support recovery unit.
      (7) The child support recovery unit shall issue a written decision to the obligor within ten calendar days of the conference.
   c. The issues to be reviewed at the conference shall be as follows:
      (1) Whether the identity of the obligor is in error.
      (2) Whether the obligor is already providing health care coverage for the dependent.
      (3) Whether the availability of dependent health care coverage is in error.
      (4) Whether the obligor was ordered to provide health care coverage under the support order.
   d. The results in an informal conference shall in no way affect the right of the obligor to file a motion to quash the order under Iowa Code section 252E.6A.

[ARC 4112C, IAB 11/7/18, effective 2/15/19]
DIVISION II
INCOME WITHHOLDING
PART A
DELINQUENT SUPPORT PAYMENTS

441—98.21(252D) When applicable. When there is a delinquency in an amount equal to the support payable for one month as specified by an order for support or reimbursement order and the child support recovery unit is providing services under 441—Chapter 95, the unit shall enter an order to withhold the obligor’s income not exempt by state or federal law to require the income withheld to be paid to the collection services center to pay the support obligation. An income withholding order shall also be entered to collect the unpaid balance of a judgment for the reimbursement of a support debt when a repayment schedule is not specified in the order establishing the judgment.

441—98.22 and 98.23 Reserved.

441—98.24(252D) Amount of withholding. The child support recovery unit shall determine the amount to be withheld by the employer or other income providers as follows:

98.24(1) Current support obligation exists. When a current support obligation exists, the amount withheld shall be an amount equal to the current support obligation, and an additional amount equal to 20 percent of the current support obligation to be applied toward the liquidation of any delinquency. However, the amount withheld to be applied toward the liquidation of any delinquency shall be 50 percent of the current support obligation for any support order entered or modified prior to July 1, 1998, and for which an income withholding order has been filed by the Iowa child support recovery unit prior to July 1, 1998.

98.24(2) Current obligation ended. When the current support obligation has ended or has been suspended, the income withholding order shall remain in effect until any delinquency has been satisfied. The amount withheld shall be equal to the amount of the most recent prior current support obligation which is greater than zero. However, in the following circumstances, the amount withheld shall be 20 percent of the amount owed for current support at the time the obligation ended or was suspended:

a. There has been a change of legal custody from the obligee to the obligor.

b. The obligee and obligor have reconciled and have obtained a modification ending the current support obligation.

c. The current obligation is suspended through the suspension process.

d. In a foster care case, the order for parental liability ended when the child left placement, or an order ending the liability has been entered and the child in foster care has returned to the home of a parent ordered to pay parental liability. In this situation, the amount withheld shall be reduced to 20 percent of the current support amount when the obligation ended, but only for the parent with whom the child resides.

98.24(3) No support ordered. When there is no current child support ordered and the obligation is solely the result of a judgment which does not specify a repayment schedule, the withholding amount shall be set at the amount for one person from the FIP schedule of basic needs.

98.24(4) Lump-sum income source. Notwithstanding subrules 98.24(1), 98.24(2), and 98.24(3), when the obligor is paid by a lump-sum income source, the withholding amount may include all current and delinquent support due through the current month. Lump-sum income includes income received in a sole payment or in payments that occur at two-month or greater intervals.

[ARC 412C, IAB 11/7/18, effective 2/15/19]

441—98.25(252D) Amendment of amount of withholding due to hardship.

98.25(1) Request for amendment. If subrule 98.24(2) or 98.24(3) applies, the obligor may request at any time an amendment of the amount withheld as payment toward the delinquency or reimbursement
on the grounds of hardship. The obligor must submit the request in writing to the child support recovery unit.

98.25(2) Hardship criterion. Hardship exists if the obligor’s income is equal to or less than 200 percent of the poverty level for one person according to the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2).

a. If hardship is claimed by the obligor, the child support recovery unit may verify income from:
   (1) The employer or other income provider of the obligor.
   (2) The obligor.
   (3) The state employment security agency.
   (4) Other records available in accordance with Iowa Code section 252B.9.

b. If the hardship criterion is met, the amount withheld as payment toward the delinquency may be amended as follows:
   (1) The obligor’s gross yearly income shall be divided by 200 percent of the established yearly gross poverty level income for one person. That amount shall be multiplied by .5. The resulting figure shall be multiplied by the most recent prior current support obligation or the amount determined pursuant to subrule 98.24(3), as applicable, to determine the amended amount. Notwithstanding this calculation, the amended amount shall not be less than $15 per month.
   (2) If criteria for withholding 20 percent toward liquidation of any delinquency are also met, the lesser of 20 percent or the amended amount determined in subparagraph 98.25(2) “b”(1) is to be withheld.

98.25(3) Hardship period. If the hardship criterion in subrule 98.25(2) is met, the child support recovery unit will grant the amended amount of withholding for a period of two years, subject to the provisions of subrule 98.25(6). However, if the obligor is receiving social security disability benefits, social security retirement benefits, or supplemental security income disability benefits, the obligor is deemed to continue to meet the hardship criterion for the duration of those benefits.

98.25(4) Denying requests. A hardship request may be denied if:
   a. The criterion in subrule 98.25(2) is not met.
   b. The obligor has been granted an amended amount of withholding based on this rule within the last two years and that hardship period will not expire in less than 30 days.
   c. The obligor’s previous hardship period expired within the last six months and, within 30 days prior to the expiration date of the previous hardship period, the obligor did not submit the following to the child support recovery unit:
      (1) A written request for hardship; or
      (2) Verification of the obligor’s income, and the child support recovery unit was not able to verify the obligor’s income as described in paragraph 98.25(2)”a.”

98.25(5) Notice requirements. The child support recovery unit will provide written notification to the obligor of the result of the hardship request.
   a. When a hardship request is granted, the written notification will include the amended amount of withholding and the date the hardship period will expire.
   b. When a hardship request is denied, the written notification will include the reason for denial.

98.25(6) Termination of hardship prior to expiration date. The hardship period will automatically end, regardless of expiration date, if any of the following occurs:
   a. A current support obligation is added to the support order.
   b. The current support obligation was previously suspended and is reinstated.
   c. The delinquency has been paid in full.
   d. The obligor was receiving social security disability benefits, social security retirement benefits, or supplemental security income disability benefits at the time the hardship request was granted, and the child support recovery unit has verified that the obligor is no longer receiving social security disability benefits, social security retirement benefits, or supplemental security income disability benefits.

[ARC 4112C, IAB 11/7/18, effective 2/15/19]
441—98.26(252D) Additional information about hardship. The child support recovery unit shall make reasonable efforts within 13 months after January 1, 2019, to identify and incrementally notify obligors who may be impacted by the changes to hardship procedures in rule 441—98.25(252D).

[AIC 4112C, IAB 11/7/18, effective 2/15/19]

These rules are intended to implement Iowa Code chapter 252D.

441—98.27 to 98.30 Reserved.

PART B
IMMEDIATE INCOME WITHHOLDING

441—98.31(252D) Effective date. In cases for which the child support recovery unit is providing enforcement services, the income of the obligor is subject to immediate withholding pursuant to Iowa Code section 252D.8 without regard to the existence of a delinquency in the payment of support.

441—98.32(252D) Withholding automatic. Immediate withholding of income is automatic without additional notice to the obligor unless:

98.32(1) Good cause exists. Good cause is found to exist by the court or the child support recovery unit. For purposes of this rule, “good cause” is defined as the posting of a secured bond by the obligor sufficient to pay all current and future child support obligations, including any delinquency which may accrue.

98.32(2) Written agreement exists. A written agreement is reached between both parties which provides for an alternative arrangement for payment of child support subject to the following conditions:

a. Unless approved by the child support recovery unit, written agreements between the obligee and obligor to waive immediate income withholding become void when child support is assigned to this state or to another state pursuant to a statute of that jurisdiction.

b. All payments pursuant to any written agreement shall be paid as directed in Iowa Code sections 252B.14 and 598.22.

[AIC 4112C, IAB 11/7/18, effective 2/15/19]

441—98.33 Reserved.

441—98.34(252D) Approval of request for immediate income withholding. When the obligee or other party to the proceeding requests immediate withholding, the child support recovery unit shall determine whether the request shall be approved.

98.34(1) Basis for approval. Approval of a request for immediate income withholding by the child support recovery unit may be based on:

a. Past payment record of the obligor which demonstrates an inconsistent compliance with the support order.

b. Whether the state of Iowa is providing public assistance.

98.34(2) Request denied. The child support recovery unit may not approve a request for immediate income withholding on cases where no public assistance has been expended and there is a prior written agreement between the obligee and obligor which has been approved by court order.

441—98.35(252D) Modification or termination of withholding. Rescinded ARC 4112C, IAB 11/7/18, effective 2/15/19.

441—98.36(252D) Immediate income withholding amounts. The amount withheld shall be the amount of the current support obligation as specified in the support order. If a judgment for accrued support is established in the support order, the amount withheld shall be the amount due for current support and the periodic payment amount due for the accrued support as specified in the order. If no periodic payment for the accrued support is established in the support order, the amount withheld shall be the amount due for current support plus 10 percent of the amount of the current obligation to be applied to the accrued support.
441—98.37(252D) Immediate income withholding amounts when current support has ended. When the child support obligation has ended, the amounts to be withheld shall be in accordance with subrule 98.24(2).

These rules are intended to implement Iowa Code chapter 252D.

441—98.38 Reserved.

PART C
INCOME WITHHOLDING—GENERAL PROVISIONS

441—98.39(252D,252E) Provisions for medical support. An income withholding order or notice of income withholding may also include provisions for enforcement of medical support when medical support is included in the support order. The income withholding order or notice of income withholding may require implementation of dependent health care coverage pursuant to Iowa Code chapter 252E or the withholding of a dollar amount for medical support. Amounts withheld for medical support shall be determined in the same manner as amounts withheld for child support.

[ARC 4112C, IAB 11/7/18, effective 2/15/19]

441—98.40(252D,252E) Maximum amounts to be withheld. An income withholding order or a notice issued by the child support recovery unit shall require that the employer or other income provider withhold no more than the maximum amounts allowed under the Federal Consumer Credit Protection Act, 15 U.S.C. Section 1673(b).

98.40(1) The amount of income subject to withholding shall be limited to 50 percent of the nonexempt disposable income of the obligor unless there is more than one support order for which the obligor is obligated and the criteria of 15 U.S.C. Section 1673(b) are met, or the obligor agrees to a greater amount within these limits.

98.40(2) Disposable income means that part of the earnings of any individual remaining after the deduction from those earnings of any amounts required by law to be withheld.

[ARC 4112C, IAB 11/7/18, effective 2/15/19]

441—98.41(252D) Multiple obligations. In the event that an obligor has more than one support obligation that is being enforced by the child support recovery unit, the unit may enter an income withholding order to enforce each obligation. The amount specified to be withheld on the delinquency under the income withholding order or notice shall be determined in accordance with rule 441—98.24(252D).

[ARC 4112C, IAB 11/7/18, effective 2/15/19]

441—98.42(252D) Notice to employer and obligor. The child support recovery unit shall send the obligor and the employer or other income provider a notice of income withholding as follows:

98.42(1) Notice to employer. The unit may send notice to the employer or other income provider by regular mail or by electronic means in accordance with Iowa Code chapter 252D. If the unit is sending notice by regular mail, it shall send Form 470-3272, Income Withholding for Support, or a notice in the standard format prescribed by 42 U.S.C. §666(b)(6)(A). If the unit is sending the notice by electronic means, it may include notice of more than one obligor’s order and need only state once provisions which are applicable to all obligors, such as the information in paragraphs 98.42(1)“d,” “f,” “g,” and “i.” The statement of provisions applicable to all obligors may be sent by regular mail or electronic means. The notice of income withholding shall contain information such as the following:

a. The obligor’s name and social security number.
b. The amount of current support to withhold.
c. The amount of support to withhold for payment of delinquent support, if any.
d. The amount an income provider may deduct for costs of processing each support payment.
e. The child support case number.
f. The location to which payments are sent.
g. The maximum amount that can be withheld for payment of support as specified in rule 441—98.40(252D,252E).
h. The method to calculate net income.
i. Responsibilities of the income provider as specified in Iowa Code section 252D.17.
j. Responsibility, if any, of the income provider to enroll the obligor’s dependent for coverage under a health benefit plan.

98.42(2) Notice to obligor. Form 470-2624, Initiation of Income Withholding/Medical Support Enforcement, shall be sent to the last-known address of the obligor by regular mail. The notice shall contain the following information:

a. A statement of the obligor’s right to an informal conference.
b. The process to request an informal conference.
c. The obligor’s right to claim hardship criteria and the process for a claim.
d. The obligor’s right to file a motion to quash the income withholding order or notice with the district court.
e. The information provided to the employer or other income provider, or a copy of the notice sent to the employer or other income provider.
f. The amount of any delinquency.

98.42(3) Standard format. As provided in Iowa Code section 252D.17, an order or notice of an order for income withholding shall be in a standard format prescribed by the child support recovery unit. Form 470-3272, Income Withholding for Support, is the standard format prescribed by the child support recovery unit, and the unit shall make a copy of the form available to the state court administrator and the Iowa state bar association.

[ARC 4112C, IAB 11/7/18, effective 2/15/19]

441—98.43(252D) Contesting the withholding. The obligor may contest the income withholding by means of an informal conference with the child support recovery unit or by filing a motion to quash.

98.43(1) Motion to quash. Procedures for filing a motion to quash the order or the notice of income withholding are specified in Iowa Code chapter 252D.

98.43(2) Informal conference.

a. The obligor shall be entitled to only one informal conference for each new or modified income withholding order or notice issued by the child support recovery unit that specifies a new or modified total amount to withhold.
b. Procedures for the informal conference are as follows:
   (1) The child support recovery unit shall inform the obligor in writing of the right to request an informal conference.
   (2) The obligor may request an informal conference with the child support recovery unit if the obligor believes the withholding is in error.
   (3) The obligor shall request an informal conference in writing.
   (4) The child support recovery unit shall schedule an informal conference within 15 calendar days of the receipt of a written request from the obligor or the obligor’s representative.
   (5) The child support recovery unit may conduct the conference in person or by telephone.
   (6) If the obligor fails to attend the conference, only one alternative time shall be scheduled by the child support recovery unit.
   (7) The child support recovery unit shall issue a written decision to the obligor within ten calendar days of the conference.
   (8) If the child support recovery unit has not complied with rule 441—98.24(252D), it shall then adjust the income withholding amount.
c. The issues to be reviewed at the conference shall be as follows:
   (1) For all income withholding orders or notices, whether:
      1. The identity of the obligor is in error.
      2. The amount of the current support obligation is in error.
(2) For orders or notices resulting from the existence of a delinquency, whether:
   1. The amount of delinquent support is in error.
   2. For income withholding orders or notices issued after November 1, 1990, whether the guidelines described at rule 441—98.24(252D) were followed.

(3) For immediate income withholding orders or notices, whether the criteria of rules 441—98.32(252D) and 441—98.34(252D) were appropriately applied.

   d. The results of an informal conference shall in no way affect the right of the obligor to file a motion to quash the income withholding order or notice with the court.

\[441—98.43(3)\] Income withholding issued from another state. The child support recovery unit shall follow procedures for a motion to quash or a request for hardship or conduct an informal conference based on an income withholding order or notice issued in another state only if the unit is providing services under 441—Chapter 95.

[ARC 4112C, IAB 11/7/18, effective 2/15/19]

\[441—98.44(252D)\] Termination of order. The child support recovery unit may, by ex parte order, terminate an income withholding order under the following conditions:

\[441—98.44(1)\] Order entered in error. The child support recovery unit shall terminate an income withholding order upon determination that the order was entered in error as follows:

   a. The person named as the obligor in the income withholding order is not the person required to provide support under the support order being enforced.
   b. For orders resulting from the existence of a delinquency, the required minimum delinquency did not exist at the time the income withholding order was entered.

\[441—98.44(2)\] No support due. In cases for which services are being provided by the child support recovery unit, the child support recovery unit shall terminate an income withholding order previously entered by the unit when the current support obligation has terminated and when the delinquent support obligation has been fully satisfied as applicable to all of the children covered by the income withholding order. In no case shall payment of overdue support be the sole basis for termination of withholding.

   a. to d. Rescinded IAB 9/1/93, effective 11/1/93.

\[441—98.44(3)\] Other circumstances. The child support recovery unit may revoke an income withholding order under other circumstances provided the conditions of Iowa Code chapter 252D are met.

\[441—98.45(252D)\] Modification of income withholding. The child support recovery unit may modify a previously issued income withholding order or notice according to the guidelines established under rule 441—98.24(252D) if it is determined that:

\[441—98.45(1)\] Current support obligation changed. There has been a change in the amount of the current support obligation.

\[441—98.45(2)\] Amount in error. The amount required to be withheld under the income withholding order or notice is in error as follows:

   a. The amount required to be withheld as current support is not the amount specified in the order for support being enforced.
   b. The guidelines established in rule 441—98.24(252D) were not followed.

\[441—98.45(3)\] Past-due support paid. Any past-due support debt has been paid in full. The withholding order or notice shall be modified to require that only the current support obligation be withheld from the income of the obligor. Should a delinquency later accrue, the withholding order or notice may again be modified to secure an additional payment toward the delinquency. The amount of the arrears payment shall be set at 20 percent of the current support amount.

\[441—98.45(4)\] Income withholding and determination of controlling orders. An obligation amount different than what the child support recovery unit has been enforcing is established upon the determination of controlling order as allowed in Iowa Code section 252K.207. Upon the change to the new obligation amount, the amount withheld to be applied toward the liquidation of any delinquency shall be 20 percent.
98.45(5) *Income withholding and review and adjustment of orders.* The child support recovery unit has conducted a review of the obligation pursuant to 441—Chapter 99, Division IV. The unit shall modify the amount withheld to be applied toward the liquidation of any delinquency to 20 percent upon completion of the review and adjustment process.

98.45(6) *Implementation or termination of amended amount of withholding due to hardship.* The child support recovery unit has determined that the withholding order should be modified based upon the hardship provisions in rule 441—98.25(252D).

[ARC 4112C, IAB 11/7/18, effective 2/15/19]

441—98.46(252D) *Refunds of amounts improperly withheld.* The child support recovery unit shall refund to the obligor any amounts improperly withheld and received by the department under an income withholding order or notice issued by the unit, subject to the following:

98.46(1) *Services provided by the department.* Only those amounts received by the department during the period enforcement services are being provided are subject to refund.

98.46(2) *Satisfaction of amount to withhold.* No refund shall be made unless amounts have been collected which fully satisfy the amount specified in the income withholding order or notice for the withholding period during which income has been generated.

98.46(3) *When issued.* Any amounts received in excess of the amounts specified in the order or notice to withhold shall be issued to the obligor within 30 days of discovery by the child support recovery unit, unless the obligor requests in writing that these amounts be credited toward the delinquency or future child support. If there is a dispute regarding whether there is an overpayment, the obligor may request an informal conference by following the procedures set out in subparagraphs 98.43(2)’a’(3) through (7). This procedure shall not preclude the obligor from utilizing other civil remedies.

98.46(4) *Recovery by department.* The department may recover payments from the obligee in excess of those described in subrule 98.46(2) which have been received by the department and improperly forwarded to the obligee.

[ARC 4112C, IAB 11/7/18, effective 2/15/19]

441—98.47(252D) *Additional information about hardship.* Rescinded ARC 4112C, IAB 11/7/18, effective 2/15/19.

These rules are intended to implement Iowa Code Supplement chapters 252D and 252E.

441—98.48 to 98.50 Reserved.

DIVISION III
review and adjustment of child support obligations

441—98.51 to 98.60 Renumbered as 99.61 to 99.70, IAB 9/1/93, effective 11/1/93.

DIVISION IV
publication of names

441—98.61(252B) *List for publication.* The department may compile and make available for publication a list of cases in which no payment has been credited to an accrued or accruing support obligation during a previous three-month period, subject to the following:

98.61(1) *Support order entered in Iowa.* The list shall include cases with a support order entered in Iowa which is being enforced by the child support recovery unit.

98.61(2) *Support order entered in another state.* The list may include cases with a support order entered in another state, if another state has requested this service, has demonstrated that the provision of this service is not in conflict with the laws of the state where the support order is entered, and the order is being enforced by the child support recovery unit.

98.61(3) *When compiled.* The department shall determine when to compile the list, but shall not be required to do so.
98.61(4) Case selection. Case selection shall be based on the records of the department at the time the list is compiled. The three-month period of nonpayment shall end no earlier than one month prior to the date the list is compiled. When an obligor has multiple orders on a case, all orders contained in the child support recovery unit record may be listed.

98.61(5) Good cause. The name of the obligor shall not be included when there has been a finding of good cause for noncooperation with the child support recovery unit in a public assistance case pursuant to 441—subrule 41.2(8) or 441—subrule 75.14(1) and a determination has been made that enforcement may not proceed without risk of harm to the child or caretaker.

441—98.62(252B) Releasing the list. The department may release the information, no more than twice annually, as follows:

98.62(1) Release to media. The department shall issue a press release to the weekly and daily newspapers in Iowa describing the manner in which a copy of the list may be obtained. Cost of producing the list shall be borne by the department. Costs of producing and transmitting a copy of the list shall be borne by the recipient of the copy.

98.62(2) Availability of list. Once released, the list shall be provided to other persons upon payment of an amount to cover the cost of producing a copy as specified in 441—subrule 9.3(7). Requests shall be directed to the Bureau of Collections, Fifth Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114.

These rules are intended to implement Iowa Code section 252B.9.

441—98.63 to 98.70 Reserved.

DIVISION V
ADMINISTRATIVE SEEK EMPLOYMENT ORDERS

441—98.71(252B) Seek employment order. The child support recovery unit (CSRU) may enter an ex parte order requiring the obligor to seek employment if employment of the obligor cannot be verified and if the obligor has failed to make support payments. Any obligor who has failed to make support payments and for whom employment cannot be verified is subject to issuance of an administrative order to seek employment.

441—98.72(252B) Effective date of order. The seek employment order shall be effective 15 days after issuance of the order to the obligor. This 15-day period shall serve as advance notice to the obligor.

441—98.73(252B) Method and requirements of reporting. The obligor shall complete Form 470-3155, Report of Seek Employment Activity, which shall be submitted to the unit on a weekly basis throughout the duration of the order unless the obligor has a valid reason for not complying with the order. The obligor shall document at least five new attempts to find employment on the form each week. The same employer may not be reported more than once per week.

The obligor shall include the names, addresses, and the telephone numbers of each of the five employers or businesses with whom the obligor attempted to seek employment and the name of the individual contact to whom the obligor made application for employment or to whom the inquiry was directed.

441—98.74(252B) Reasons for noncompliance. Upon verification, certain conditions shall be considered valid reasons for noncompliance. At the request of the child support recovery unit (CSRU), the obligor shall provide verification of any reason for noncompliance with the order when the information is not available to CSRU through online sources. Valid reasons for noncompliance and acceptable verification are:

98.74(1) Receipt of social security, supplemental security income (SSI), or the family investment program (FIP). Receipt of social security, SSI, or FIP is considered a valid reason for noncompliance
when verified by information contained in online sources available to CSRU or written verification from the agency providing the benefits.

98.74(2) Temporary illness or disability. Temporary illness or disability of the obligor or other household member is considered a valid reason upon receipt of completed Form 470-3158, Physician’s Statement, verifying the obligor’s inability to seek or accept employment.

98.74(3) High school student. Attending high school is considered a valid reason upon verification from the high school.

98.74(4) Incarceration. Incarceration is considered a valid reason when verified through online information available to CSRU or on receipt of verification from the institution.

98.74(5) Substance abuse treatment. Participating in a supervised substance abuse treatment program that is associated with a treatment center is considered a valid reason upon verification from the treatment center.

98.74(6) Job training. Participation in a job training or job seeking program through the department of employment services as a result of receiving food stamps is considered a valid reason upon receipt of verification from the department of employment services.

98.74(7) Employment or self-employment. Employment or self-employment is considered a valid reason upon verification through the employer for those employed or through tax documents or business records for those self-employed.

98.74(8) Payment of support. Payment on the account equal to the amounts prescribed for income withholding in accordance with rule 441—98.24(252D) throughout the duration of the seek employment order is considered a valid reason upon verification of payments posted to the Iowa collection and reporting (ICAR) system.

441—98.75(252B) Method of service. The seek employment order shall be served on the obligor by regular mail. Proof of service shall be completed in accordance with Iowa Rules of Civil Procedure, Number 82.

441—98.76(252B) Duration of order. The seek employment order shall remain in effect for three months from the date of issuance unless CSRU determines the obligor has a valid reason for noncompliance as specified at rule 441—98.74(252B), at which time the order becomes unenforceable.

Upon acceptance of the reason for noncompliance, CSRU shall notify the obligor that the obligor is no longer required to comply with the seek employment order. Upon denial of the reason for noncompliance, CSRU shall notify the obligor that the obligor shall comply with the existing seek employment order. The notice shall be filed with the clerk of the district court. If the obligor disputes this decision, the obligor shall have recourse through the district court.

These rules are intended to implement Iowa Code section 252B.21.

441—98.77 to 98.80 Reserved.

DIVISION VI
DEBTOR OFFSET

441—98.81(252B) Offset against payment owed to a person by a state agency. The department will make a claim against a payment owed to an obligor by a state agency when support payments are delinquent as set forth in rule 11—40.1(8A). A claim against a payment owed to an obligor shall be applied to court-ordered support which the department is attempting to collect pursuant to Iowa Code chapter 252B.

98.81(1) Case selection. The department shall submit to the department of administrative services, at least monthly, a list of obligors who are delinquent at least $50 in support payments.

98.81(2) Notification of offset. Within ten days of receiving notification from the department of administrative services that the obligor is entitled to a payment, the department shall:
a. Send a preoffset notice to the obligor. The preoffset notice shall inform the obligor of the amount the department intends to claim and apply to the support obligation and shall contain all information required by Iowa Code subsection 8A.504(2) and 11—subrule 40.4(4).

b. Notify the department of administrative services that the preoffset notice has been sent to the obligor.

98.81(3) Appeal process. An obligor may contest the department’s claim by submitting a written request to the department. A hearing shall be granted pursuant to rules in 441—Chapter 7 if the obligor’s request is submitted within 15 days of the date of the preoffset notice.

98.81(4) Joint owner. A joint owner’s proportionate share of the payment, as determined by the department of administrative services, shall be released unless other claims are made on that portion of the payment. The department must receive a request for release of a joint owner’s share within 15 days of the date of the preoffset notice. The request may be made by either owner.

98.81(5) Final disposition of offset. The department shall notify an obligor of the final decision regarding the claim against the offset by sending a final disposition of support recovery claim notice to the obligor.

98.81(6) Distribution of offset amount. Offsets shall be applied in accordance with rules 441—95.3(252B) and 441—95.4(252B).

98.81(7) Percentage of payment offset. The amount of offset shall be 50 percent of the total payment due the obligor, unless the payment results from lottery winnings, from gambling winnings, or from a payment for a claim under treasurer of state rules on unclaimed property at 781—Chapter 9, in which case the amount of offset shall be 100 percent of the payment. The amount taken shall not exceed the delinquent amount owed by the obligor.

This rule is intended to implement Iowa Code sections 252B.3 and 252B.4 and Iowa Code subsection 8A.504(2).

[ARC 9177B, IAB 11/3/10, effective 1/1/11]

441—98.82 to 98.90 Reserved.

DIVISION VII
ADMINISTRATIVE LEVY

441—98.91(2521) Administrative levy. When there is a delinquency in an amount equal to the ordered support payable for one month, the child support recovery unit may issue an administrative levy to the obligor’s financial institution.

441—98.92 Reserved.

441—98.93(2521) Verification of accounts. The unit may contact a financial institution to obtain verification of the account number, the names and social security numbers listed on the account, and the account balance for an obligor’s account. This contact may be by telephone or written communication on Form 470-3170, Asset Verification Form, or by computer printout.

441—98.94(2521) Notice to financial institution. The unit may send a notice to the financial institution with which the account is placed, directing that the financial institution forward to the collection services center all or a portion of the moneys in the obligor’s account or accounts on the date the notice is received. The notice shall be sent by first-class mail, with proof of service completed according to rule of civil procedure 82. The notice to the financial institution shall contain all of the information specified in Iowa Code chapter 2521.

441—98.95(2521) Notice to support obligor. The unit shall notify an obligor, and any other party known to have an interest in the account, of the action. The notice shall contain all of the information specified in Iowa Code chapter 2521. The unit shall forward the notice by first-class mail within two working days.
of sending the notice to the financial institution. Proof of service shall be completed according to Iowa Rules of Civil Procedure 82.

441—98.96(252I) Responsibilities of financial institution. Upon receipt of the notice of administrative levy, the financial institution shall follow procedures specified in Iowa Code section 252I.7 for encumbering and forwarding funds to collection services center. The financial institution shall encumber only the funds in the obligor’s account on the day the notice is received. Any deposits made by the obligor after notice is received by the financial institution are not subject to the administrative levy process unless another notice is issued to the financial institution.

441—98.97(252I) Challenging the administrative levy. An obligor or an account holder of interest may challenge the administrative levy by submitting a written challenge to the person identified as the contact for the unit in the notice, within ten working days of the date of the notice to the obligor as specified in rule 441—98.95(252I). Upon receipt of a challenge, the unit shall follow criteria and procedures specified in Iowa Code section 252I.8 for resolving the challenge.

98.97(1) Review of facts. The unit shall, upon receipt of a written challenge, review the facts of the case with the challenging party. Only a mistake of fact including, but not limited to, a mistake in the identity of the obligor or a mistake in the amount of delinquent support due shall be considered as a reason to dismiss or modify the proceeding. If the unit determines that a mistake of fact has occurred, the unit shall proceed as follows:

a. If a mistake in identity has occurred or the obligor is not delinquent in an amount equal to the payment for one month, the unit shall notify the financial institution and the obligor that the administrative levy has been released.

b. If the amount of support due was incorrectly overstated, the unit shall notify the financial institution to release the excess moneys to the obligor and remit the remaining moneys.

98.97(2) Refunds of amounts improperly held. If a mistake of fact has occurred and money has already been forwarded from the financial institution, the unit shall proceed as follows:

a. If a mistake in identity has occurred or the obligor is not delinquent in an amount equal to the payment for one month, the unit shall refund the funds to the account and reimburse the account for any fees assessed by the financial institution.

b. If the amount of support due was incorrectly overstated, the unit shall refund a portion to the account. The unit is not required to reimburse the account for fees.

98.97(3) Request for district court hearing. If no mistake of fact is found, the unit shall send a notice to the challenging party by first-class mail. An obligor or an account holder may submit a second written challenge to the person identified as the contact for the unit in the notice, within ten working days of the date of the notice. The unit shall request a hearing before the district court in the county the support order is filed. Procedures for filing a hearing are specified in Iowa Code chapter 252I.

98.97(4) Request for withdrawal. The challenging party may withdraw the challenge by submitting a written withdrawal to the person identified as the contact person for the unit in the notice at any time prior to the court hearing. The unit may withdraw the administrative levy at any time prior to the court hearing. The unit shall provide notice of the withdrawal to the financial institution and any account holder of interest by first-class mail.

These rules are intended to implement Iowa Code chapter 252I.

441—98.98 to 98.100 Reserved.

DIVISION VIII
LICENSE SANCTION

441—98.101(252J) Referral for license sanction. In the process referred to as license sanction, the child support recovery unit (CSRU) may refer an individual to a licensing agency for the suspension, revocation, nonissuance, or nonrenewal of a variety of licenses including, but not limited to, motor
vehicle registrations, driver’s licenses, business and professional licenses, and licenses for hunting, fishing, boating, or other recreational activity. In order to be referred to a licensing agency for license sanction, one of the following must apply:

98.101(1) Delinquent support payments. An obligor’s support payments must be delinquent in an amount equal to the support payment for three months. CSRU may first refer for license sanction those obligors having the greatest number of months of support delinquency. CSRU shall not refer obligors whose support payments are being made under an income withholding order.

98.101(2) Subpoena or warrant. An individual must have failed to comply with a subpoena or warrant, as defined in Iowa Code chapter 252J, relating to a paternity or support proceeding. If a subpoena was issued, the individual must have failed to comply with either Form 470-3413, Child Support Recovery Unit Subpoena, or an Interstate Subpoena as provided in paragraph 96.2(1) “a” within 15 days of the issuance of the subpoena, and proof of service of the subpoena was completed according to Rule of Civil Procedure 82.

441—98.102(252J) Reasons for exemption. Certain conditions shall be considered valid reasons for exemption from the license sanction process. Upon verification of these conditions, CSRU shall bypass, exempt, or withdraw the individual’s name from referral to licensing agencies for the purpose of applying a license sanction. When the information to verify the exemption is not available to CSRU through online sources, CSRU shall request, and the individual shall provide, verification of the reason for exemption. Valid reasons for exemption for failure to comply with a subpoena or warrant and acceptable verification are those listed in subrules 98.102(2), 98.102(3), 98.102(5), and 98.102(6). Valid reasons for exemption for delinquent support payments and acceptable verification are any of the following:

98.102(1) Receipt of social security, supplemental security income (SSI) or the family investment program (FIP). Receipt of social security, SSI, FIP, or county assistance (general relief, general assistance, community services, veteran’s assistance), based upon the eligibility of the obligor, is considered a valid reason for exemption when verified by information contained in online sources available to CSRU or written verification from the agency providing the benefits.

98.102(2) Temporary illness or disability. Temporary illness or disability of the individual or illness or disability of another household member which requires the presence of the individual in the home as caretaker is considered a valid reason for exemption upon receipt of a completed Form 470-3158, Physician’s Statement, verifying the individual’s or household member’s inability to work.

98.102(3) Incarceration. Incarceration is considered a valid reason for exemption when verified through online information available to CSRU or upon receipt of verification from the institution.

98.102(4) Job training. Participation in a job-training or job-seeking program through the department of employment services as a result of receiving food stamps is considered a valid reason for exemption upon receipt of verification from the department of employment services or verification through online information available to CSRU or upon receipt of a written statement from an income maintenance worker.

98.102(5) Chemical dependency treatment. Participation in a chemical dependency treatment program that is licensed by the department of public health or the joint commission on the accreditation of hospitals (JCAH) is considered a valid reason for exemption upon receipt of written verification from the professional staff of the program that participation in the program precludes the individual from working.

98.102(6) Contempt process. Involvement in a contempt action dealing with support issues is considered a valid reason for exemption from the license sanction process during the pendency of the contempt action.

441—98.103(252J) Notice of potential sanction of license. When an individual meets the criteria for selection, CSRU may issue a notice to the individual of the potential sanction of any license held by the individual, using Form 470-3278, Official Notice of Potential License Sanction.

98.103(1) Delinquent support payments. CSRU shall inform the obligor that the obligor may make immediate payment of all current and past due child support, schedule a conference to review the action
of CSRU, or request to enter into a payment agreement with the unit. CSRU shall follow the procedures and requirements of Iowa Code chapter 252J regarding the issuance of the notice and the holding of a conference.

98.103(2) Subpoena or warrant. CSRU shall inform the individual that the individual may comply with the subpoena or warrant, or schedule a conference to review the action of CSRU. CSRU shall follow the procedures and requirements of Iowa Code chapter 252J regarding the issuance of the notice and the holding of a conference.

98.103(3) Certificate of noncompliance. If an individual fails to respond in writing to the notice within 20 days, or if the individual requests a conference and fails to appear, the unit shall issue a Certificate of Noncompliance, Form 470-3274, to applicable licensing authorities in accordance with Iowa Code section 252J.3.

441—98.104(252J) Conference.

98.104(1) Scheduling of conference. Upon receipt from an individual of a written request for a conference, CSRU shall schedule a conference not more than 30 days in the future. At the request of either CSRU or the individual, the conference may be rescheduled one time. When setting the date and time of the conference, if notice was sent to an obligor under subrule 98.103(1), CSRU shall request the completion of Form 470-0204, Financial Statement, and other financial information from both the obligor and the obligee as may be necessary to determine the obligor’s ability to comply with the support obligation.

98.104(2) Payment calculation. If notice was sent to an obligor under subrule 98.103(1) during the conference held in compliance with the provisions of Iowa Code section 252J.4, CSRU shall determine if the obligor’s ability to pay varies from the current support order by applying the mandatory supreme court guidelines as contained in 441—Chapter 99, Division I, with the exception of subrules 99.4(3) and 99.5(5). If further information from the obligor is necessary for the calculation, CSRU may schedule an additional conference no less than ten days in the future in order to allow the obligor to present additional information as may be necessary to calculate the amount of the payment. If, at that time, the obligor fails to provide the required information, CSRU shall issue a Certificate of Noncompliance, Form 470-3274, to applicable licensing authorities. If the obligee fails to provide the necessary information to complete the calculation, CSRU shall use whatever information is available. If no income information is available for the obligee, CSRU shall determine the obligee’s income in accordance with 441—subrules 99.1(2) and 99.1(4). This calculation is for determining the amount of payment for the license sanction process only, and does not modify the amount of support obligation contained in the underlying court order.

98.104(3) Referral for review and adjustment. If the amount calculated in subrule 98.104(2) meets the criteria for review and adjustment as specified in rule 441—99.62(252B,252H), or administrative modification as specified in rule 441—99.82(252H) and subrules 441—99.83(1), 99.83(2) and 99.83(6) at the time CSRU provides the payment agreement to the obligor, CSRU shall also provide the obligor with any necessary forms to request a review and adjustment or administrative modification of the support obligation. The payment agreement remains in effect during the review and adjustment or administrative modification process.

441—98.105(252J) Payment agreement. The License Sanction Payment Agreement, Form 470-3273, shall require the obligor to pay the lower of the amount calculated in subrule 98.104(2) or the maximum amount payable under an income withholding order as specified in rule 98.24(252D).

98.105(1) Duration of payment agreement. The License Sanction Payment Agreement signed under this division shall remain in effect for at least one year from the date of issuance unless CSRU determines the obligor has a valid reason for exemption as specified in rule 98.102 (252J). Except in those cases in which review and adjustment are in process, CSRU may, at the end of the year, begin the process of reviewing the case to ensure that the payment amount continues to accurately reflect the obligor’s ability to pay as calculated in subrule 98.104(1).

98.105(2) Failure to comply. If at any time following the signing of a payment agreement the obligor fails to comply with all the terms of the agreement, CSRU shall issue a Certificate of Noncompliance,
Form 470-3274, to applicable licensing authorities in accordance with the provisions of Iowa Code chapter 252J.

441—98.106(252J) Staying the process due to full payment of support. If the obligor, at any time, pays the total support owed, both current and past due, or an individual complies with the subpoena or warrant, CSRU shall stay the process, and any Certificate of Noncompliance, Form 470-3274, which has been issued shall be withdrawn by CSRU.

441—98.107(252J) Duration of license sanction. The Certificate of Noncompliance, Form 470-3274, shall remain in effect until the obligor pays all support owed, both arrears and current; or the obligor enters into a payment agreement with CSRU; or the obligor meets one of the criteria for exemption specified at subrules 98.102(1), 98.102(2), and 98.102(4); or the individual complies with the subpoena or warrant.

These rules are intended to implement Iowa Code chapter 252J as amended by 1997 Iowa Acts, House File 612, division X.

441—98.108 to 98.120 Reserved.

DIVISION IX
EXTERNAL ENFORCEMENT

PREAMBLE

This division implements provisions of 1997 Iowa Acts, House File 612, sections 35 and 244, which provide for enforcement of child support arrearages by external sources. These sources are entities under contract to collect difficult-to-collect arrearages and private attorneys acting independently of the unit but with the unit’s consent. The rules provide criteria and procedures for referral of delinquent support to collection contractors, assessment of the statutory surcharge, and opportunity for the delinquent parent to contest. The rules also provide a procedure to allow state payment to private attorneys enforcing child support recovery unit (CSRU) cases and provide criteria to exempt cases from the procedure.

441—98.121(252B) Difficult-to-collect arrearages. The child support recovery unit may refer difficult-to-collect arrearages to a collection entity under contract with the unit or with another state entity. Upon referral, a surcharge, in addition to the support, shall be due and payable by the obligor as provided in 1997 Iowa Acts, House File 612, section 244.

98.121(1) Difficult-to-collect arrearage. A difficult-to-collect arrearage is one based upon a court or administrative order which meets all the following criteria:

a. There is no order for current support and only an arrearage is owing.

b. There has been no payment, except for federal or state tax refund offset payments, in the past three months.

c. There is no valid reason for exemption from the referral and surcharge process. Valid reasons for exemption and acceptable verification are those listed in subrules 98.102(1), 98.102(3), and 98.102(6). Upon verification of those conditions, the child support recovery unit shall bypass or exempt the obligor’s arrearages from the referral and surcharge process. When the information to verify the exemption is not available to the child support recovery unit through online sources, the child support recovery unit shall request, and the obligor shall provide, verification of the reason for exemption.

98.121(2) Notice of the possibility of referral and surcharge. The child support recovery unit shall provide notice of the possibility of a referral and surcharge to the obligor as required by 1997 Iowa Acts, House File 612, section 244. The notice shall be provided at least 15 days before the unit sends the notice of referral and surcharge to the obligor, subject to the following:

a. Notification contained in order. When the support order under which the arrearage has accrued contains language advising of statutory provisions for referral and surcharge, no other preliminary notice shall be required.
b. Notification issued by the child support recovery unit. When the support order under which the arrearage has accrued does not contain language regarding the statutory provisions for referral and surcharge, or was entered under a foreign jurisdiction and notification was not included in the support order or provided as a separate written notice, the child support recovery unit shall issue a notice to the obligor. The notice shall be sent by regular mail to the obligor’s last-known address.

98.121(3) Notice of referral and surcharge. The child support recovery unit shall send notice of a referral and surcharge to the obligor by regular mail to the obligor’s last-known address, with proof of service completed according to Rule of Civil Procedure 82. The notice shall contain all the information required by 1997 Iowa Acts, House File 612, section 244. The notice shall be sent at least 30 days before the unit refers the arrearage to the collection entity.

98.121(4) Contesting the referral and surcharge. An obligor may contest the referral and surcharge. The right to contest is limited to a mistake of fact including but not limited to a mistake in the identity of the obligor, a mistake as to whether there was a payment in the three months before the date of the notice specified in subrule 98.121(3), a mistake as to whether an exemption in paragraph 98.121(1) “c” applies, or a mistake in the amount of arrearages.

a. An obligor may contest the referral and surcharge by submitting a written request for a review to the unit within 20 days of the date on the notice of referral and surcharge specified in subrule 98.121(3). Upon receipt of a written request for review, the unit shall follow the criteria and procedures specified in 1997 Iowa Acts, House File 612, section 244, for resolving the request.

(1) If the unit determines there is a mistake in the identity of the obligor, if there was a payment, other than a federal or state income tax offset, within the three months before the date of the notice specified in subrule 98.121(3), or if there is another mistake of fact and the arrearage does not meet the criteria for referral, the unit shall issue a written notice to the contestant or obligor of the determination and not refer the arrearages. If the unit later determines an arrearage may be subject to referral, it shall issue a new notice as provided in subrule 98.121(3).

(2) If the unit determines there was a mistake in the amount of arrearages, but the corrected amount of arrearages will still be referred, or if the unit determines there is no mistake of fact, the unit shall issue a written notice of the determination of the review to the obligor by regular mail to the last-known address of the obligor. The notice shall include the amount of the arrearages that will be referred and the surcharge which will be assessed. The notice shall also include information on requesting an additional review by the bureau chief, and on requesting a judicial hearing. For purposes of this rule, bureau chief shall mean “bureau chief” as defined in rule 441—95.1(252B).

b. An obligor may contest the notice of determination of review by submitting a written request for an additional review by the bureau chief within 20 days of the date of the notice of determination of the review issued under paragraph “a.” Upon receipt of the written request for additional review, the bureau chief shall review the facts of the case.

(1) If the bureau chief determines a mistake in the identity of the obligor has occurred, if there was a payment, other than a federal or state income tax offset, within the three months before the date of the notice specified in subrule 98.121(3), or if there is another mistake of fact and the arrearage does not meet the criteria for referral, the bureau chief shall issue a written notice to the contestant or obligor of the determination and the arrearages shall not be referred. If the unit later determines an arrearage may be subject to referral, it shall issue a new notice as provided in subrule 98.121(3).

(2) If the bureau chief determines that there was a mistake in the amount of the arrearage but the corrected amount of arrearages will still be referred, or if there is no mistake of fact, the bureau chief shall send a written notice of the additional review determination to the obligor by regular mail to the last-known address of the obligor. The notice shall include the amount of the arrearage that will be referred and the surcharge which will be assessed. The notice shall also include information on requesting a judicial hearing.

c. Following the issuance of a notice of determination of a review under paragraph “a,” or issuance of a notice of determination of an additional review under paragraph “b,” the obligor may request a district court hearing. The obligor shall make a request by sending a written request for a hearing to the unit within ten days of the date of the unit’s written determination of the review, or within
ten days of the date of the bureau chief’s written determination of an additional review, whichever is later. Procedures for a district court hearing are specified in 1997 Iowa Acts, House File 612, section 244.

d. The unit shall not refer arrearages and assess a surcharge until after completion of any review, additional review or judicial hearing process.

98.121(5) Referral and surcharge.

a. If the obligor has not paid the arrearage, has not contested the referral, or if, following the unit’s review, the bureau chief’s additional review, and any judicial hearing, the unit, bureau chief, or court does not find a mistake of fact, the arrearage shall be referred to the collection entity.

b. The amount of the arrearage referred shall be the amount that is unpaid as of the date of the referral. The amount of the surcharge shall be an amount equal to the amount of the arrearage unpaid as of the date of the referral, multiplied by the percentage specified in the contract with the collection entity.

c. The child support recovery unit shall file a notice of the surcharge with the clerk of the district court in the county in which the underlying support order is filed.

This rule is intended to implement 1997 Iowa Acts, House File 612, section 244.

[ARC 4576C, IAB 7/31/19, effective 9/4/19]

441—98.122(252B) Enforcement services by private attorney entitled to state compensation. An attorney licensed to practice law in Iowa may utilize judicial proceedings to collect support, at least a portion of which is assigned support, and be entitled to compensation by the state as provided in 1997 Iowa Acts, House File 612, section 35.

98.122(1) Eligible cases. To be eligible for attorney services with compensation under this rule, a case must meet all of the following:

a. The child support recovery unit is providing services under Iowa Code chapter 252B.

b. The current support obligation is terminated and only arrearages are due under the administrative or court order.

c. There has been no payment under any order in the case for at least a 12-month period prior to the provision of the notice from the attorney to the unit under paragraph “f.”

d. At least a portion of the arrearages due under any order in the case is assigned to the state because cash assistance was paid under 1997 Iowa Acts, Senate File 516, sections 2 through 24 and 35.

e. The case does not have any of the following characteristics:

(1) There has been a finding of good cause or other exception pursuant to Iowa Code section 252B.3 as amended by 1997 Iowa Acts, House File 612, section 26.

(2) A portion of the arrears is assigned to another state because of public assistance provided by that state.

(3) Another attorney has already notified the unit of the intent to initiate a judicial proceeding to collect support due under any order in the same case under this rule, and either the time to receive the collection has not expired or the unit has not received a notice from the other attorney that the judicial proceeding has concluded prior to the expiration of the time period.

(4) If the notice from the attorney under paragraph “f” specifies contempt of court as the judicial proceeding, and the unit has generated a seek employment order to the obligor under Iowa Code section 252B.21 less than nine months prior to the date on the notice from the attorney.

(5) The case or arrearages have been referred by the child support recovery unit to a collection entity under Iowa Code section 252B.5, subsection 3, as amended by 1997 Iowa Acts, House File 612, section 30, or 1997 Iowa Acts, House File 612, section 244, less than nine months prior to the date on the notice from the attorney.

(6) The obligor has filed for bankruptcy and collection activities are stayed.

(7) The notice from the attorney under paragraph “f” lists a specific judicial proceeding and the unit has already initiated the same type of proceeding in court.

(8) The case has been referred to the U.S. Attorney’s office and is still pending at that office.

f. The attorney has provided written notice to the central office of the child support recovery unit in Des Moines, as specified in subrule 98.122(2), and to the last-known address of the obligee of the intent
to initiate a specified judicial proceeding to collect support on any identified court or administrative order involving the obligor and obligee in the case.

g. The attorney has provided documentation of insurance to the unit as required by 1997 Iowa Acts, House File 612, section 35.

h. The collection must be received by the collection services center within 90 days of the notice from the attorney in paragraph “f,” or within a subsequent 90-day extension period.

98.122(2) Procedure.

a. To begin the process under this rule, the attorney shall submit the following to the External Services Process Specialist, Bureau of Collections, Iowa Department of Human Services, Hoover Building, Fifth Floor, Des Moines, Iowa 50319-0114 at least 30 days prior to initiating the specified judicial proceeding:

(1) A dated, written statement which lists the specific judicial proceeding which the attorney intends to initiate, any court or administrative order under which the arrearages accrued identified by the order number, and the names of the obligor and obligee.

(2) Documentation that the attorney is insured as required by the statute. Documentation shall be either a copy of the attorney’s policy from the insurer, or a letter from the insurer verifying insurance coverage as required by the statute.

(3) Documentation that the attorney is licensed to practice law in Iowa.

b. The unit shall mail a response to the attorney within ten days of receipt of the notice from the attorney. All of the following shall apply to the unit’s response:

(1) If the case meets the requirements of this rule, the notice shall list the case number, any order numbers, the judicial proceeding specified by the attorney, the balance due the state of Iowa, the balance due an obligee, and the date that is 90 days from the date of the notice from the attorney. The notice shall also contain a statement that any compensation due the attorney as a result of application of this rule will be calculated on the amount of support credited to arrearages due the state at the time the support paid as a result of the judicial proceeding is received by the collection services center. The notice shall also contain a statement that any support collected shall be disbursed in accordance with federal requirements, and any support due the obligee shall be disbursed to the obligee prior to disbursement to the attorney as compensation.

(2) If the case does not meet the requirements of this rule, the notice shall list the case number, any order number, and the reason the case does not meet the requirements.

c. If the case is eligible under this rule, the attorney may initiate judicial proceedings after 30 days after providing the notice to child support recovery unit in paragraph “a.” Section 35 of 1997 Iowa Acts, House File 612, defines “judicial proceedings.”

d. The attorney may extend the time to complete the judicial proceeding or to allow for receipt of the collection by the collection services center by submitting a notice requesting a 90-day extension to the address in paragraph “a.” This or any subsequent notice must be received by the unit before expiration of the current 90-day time frame. The child support recovery unit shall acknowledge receipt of the subsequent notice and list on the acknowledgment the date that is 90 days from the date of the attorney’s subsequent notice.

98.122(3) Collection and payment to attorney.

a. Upon compliance with the requirements of 1997 Iowa Acts, House File 612, section 35, and this rule, the attorney shall be entitled to compensation from the state as provided for in this rule.

b. Upon receipt of a file-stamped copy of a court order which identifies the amount of support collected as a result of the judicial proceeding and which does not order the payment of attorney fees by the obligor, and the receipt of the collection by the collection services center, all the following apply:

(1) Section 35 of 1997 Iowa Acts, House File 612, specifies the formula to calculate the compensation due the attorney from the state. The child support recovery unit shall calculate the compensation due the attorney based upon the amount of support which is credited to arrearages due the state at the time the collection is received by the collection services center. After calculating the amount due the attorney, the unit shall reduce the amount due the attorney by the amount of any penalty or sanction imposed upon the state as a result of any other judicial proceeding initiated by that attorney.
under 1997 Iowa Acts, House File 612, section 35. The child support recovery unit shall send the attorney a notice of the amount of the compensation due from the state.

(2) The collection services center shall disburse any support due an obligee prior to payment of compensation to the attorney.

(3) The child support recovery unit shall not authorize disbursement of compensation to the attorney until the later of 30 days after receipt of the collection and the file-stamped copy of the order, or resolution of any timely appeal by the obligor or obligee.

(4) The amount of compensation due the attorney is subject to judicial review upon application to the court by the attorney.

This rule is intended to implement 1997 Iowa Acts, House File 612, section 35. These rules are intended to implement Iowa Code chapter 252D.

[Filed emergency 7/13/90—published 8/8/90, effective 8/15/90]
[Filed 8/16/90, Notice 6/27/90—published 9/5/90, effective 11/1/90]
[Filed 9/28/90, Notice 8/8/90—published 10/17/90, effective 12/1/90]
[Filed emergency 10/12/90 after Notice of 8/22/90—published 10/31/90, effective 10/13/90]
[Filed 10/12/90, Notice 8/22/90—published 10/31/90, effective 1/1/91]
[Filed 8/14/92, Notice 7/8/92—published 9/2/92, effective 11/1/92]
[Filed 8/12/93, Notice 6/23/93—published 9/1/93, effective 11/1/93]
[Filed 10/12/94, Notice 8/17/94—published 11/9/94, effective 1/1/95]
[Filed 6/7/95, Notice 4/26/95—published 7/5/95, effective 9/1/95]
[Filed 11/16/95, Notice 9/27/95—published 12/6/95, effective 2/1/96]
[Filed 2/14/96, Notice 12/20/95—published 3/13/96, effective 5/1/96]
[Filed 7/10/96, Notice 5/8/96—published 7/31/96, effective 10/1/96]
[Filed 10/9/96, Notice 8/28/96—published 11/6/96, effective 1/1/97]
[Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]
[Filed emergency 6/10/98—published 7/1/98, effective 7/1/98]
[Filed 8/12/98, Notice 7/1/98—published 9/9/98, effective 11/1/98]
[Filed 4/15/99, Notice 2/10/99—published 5/5/99, effective 7/1/99]
[Filed 4/11/01, Notice 2/21/01—published 5/2/01, effective 7/1/01]
[Filed 4/10/03, Notice 2/19/03—published 4/30/03, effective 7/1/03]
[Nullified rules editorially removed 6/8/05, effective July 1, 2005]1
[Filed 5/12/06, Notice 2/15/06—published 6/7/06, effective 9/1/06]
[Filed emergency 1/19/07—published 2/14/07, effective 1/20/07]
[Filed 10/10/07, Notice 8/1/07—published 11/7/07, effective 1/1/08]
[Filed ARC 9177B (Notice ARC 9026B, IAB 8/25/10), IAB 11/3/10, effective 1/1/11]
[Nullified rule editorially removed, IAC Supplement 12/28/11]2
[Filed ARC 4112C (Notice ARC 3972C, IAB 8/29/18), IAB 11/7/18, effective 2/15/19]
[Filed ARC 4576C (Notice ARC 4441C, IAB 5/22/19), IAB 7/31/19, effective 9/4/19]

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CHAPTER 99
SUPPORT ESTABLISHMENT AND ADJUSTMENT SERVICES

PREAMBLE

This chapter contains rules governing the provision of services by the child support recovery unit regarding: the establishment of paternity; the establishment of support obligations in accordance with the mandatory guidelines set by the Iowa Supreme Court; the review and adjustment of support obligations; the modification of support obligations; and the suspension and reinstatement of support obligations. The rules in this chapter pertain only to administrative actions or procedures used by the unit in providing the services identified. This chapter shall not be interpreted to limit the unit’s authority to use other means as provided for by state or federal statute, including, but not limited to, judicial procedures in providing these services.

DIVISION I
CHILD SUPPORT GUIDELINES

441—99.1(234,252B,252H) Income considered. The child support recovery unit shall consider all regularly recurring income of both legal parents to determine the amount of the support award in accordance with the child support guidelines prescribed by the Iowa Supreme Court. These rules on child support guidelines shall not apply if the child support recovery unit is determining the support amount by a cost-of-living alteration as provided in Iowa Code chapter 252H, subchapter IV.

99.1(1) Exempt income. The following income of the parent is exempt in the establishment or modification of support:
   a. Income received by the parent under the family investment program (FIP).
   b. Income or other benefits derived from public assistance programs funded by a federal, state, or local governmental agency or entity that are listed in rule 441—41.27(239B) as exempt from consideration in determining eligibility under FIP.
   c. Income such as child support, social security dependent benefits received by a parent for a child because of the other parent’s disability, and veteran’s dependent benefits received by a parent on behalf of a child.
   d. Stepparent’s income.
   e. Income of a guardian who is not the child’s parent.
   f. Income of the child’s siblings.
   g. Earned income tax credit.

99.1(2) Determining income. Any of the following may be used in determining a parent’s income for establishing or modifying a support obligation:
   a. Income reported by the parent in a financial statement.
   b. Income established by any of the following:
      (1) Income verified by an employer or other source of income.
      (2) Income reported to the department of workforce development.
      (3) For a public assistance recipient, income reported to the department of human services caseworker assigned to the public assistance case.
      (4) Other written documentation that identifies income.
   c. Income as determined through occupational wage rate information published by the Iowa workforce development department or other state or federal agencies.
   d. The median income for parents on the CSRU caseload, calculated annually.
   e. Social security dependent benefits. Social security dependent benefits paid for a child because of a parent’s disability shall be included in the disabled parent’s income. Social security dependent benefits paid for a parent due to the other parent’s disability shall be included in the receiving parent’s income.

99.1(3) Verification of income. Verification of income and allowable deductions from each parent shall be requested.
a. Verification of income may include, but is not limited to, the following:
   (1) Federal and state income tax returns.
   (2) W-2 statements.
   (3) Pay stubs.
   (4) Signed statements from an employer or other source of income.
   (5) Self-employment bookkeeping records.
   (6) Award letters confirming entitlement to benefits under a program administered by a government or private agency such as social security, veterans’ or unemployment benefits, military or civil service retirement or pension plans, or workers’ compensation.

b. Cases in which the information or verification provided by a parent is questionable or inconsistent with other circumstances of the case may be investigated. If the investigation does not reveal any inconsistencies, the financial statement and other documentation provided by the parent shall be used to establish income.

c. If discrepancies exist in the financial statement provided by the parent and additional income information is not available, the child support recovery unit may:
   (1) Request a hearing before the court if attempting to establish a support order through administrative process.
   (2) Conduct discovery if a parent places the matter before the court by answering a petition or requesting a hearing before the court.
   (3) When attempting to establish a default order, provide the court with a copy of the parent’s financial information and the reasons the information may be questionable.

d. If the child support recovery unit is unable to obtain verification of a parent’s income, the financial statement provided by the parent may be used to establish support.

99.1(4) Use of occupational wage rate information or median income for parents on the CSRU caseload. Occupational wage rate information or median income for parents on the CSRU caseload shall be used to determine a parent’s income when the parent has failed to return a completed financial statement when requested, and when complete and accurate income information from other readily available sources cannot be secured.

a. Occupation known. When the last-known occupation of a parent can be determined through a documented source including, but not limited to, Iowa workforce development or the National Directory of New Hires, occupational wage rate information shall be used to determine income. When the last-known occupation of a parent cannot be determined through a documented source, information may be gathered from the other parent and occupational wage rate information applied. Wage rate information shall be converted to a monthly amount in accordance with subrule 99.3(1).

b. Occupation unknown. When the occupation of a parent is unknown, CSRU shall estimate the income of a parent using the median income amount for parents on the CSRU caseload.

99.1(5) Self-employment income. A self-employed parent’s adjusted gross income, rather than the net taxable income, shall be used in determining net income. The adjusted gross income shall be computed by deducting business expenses involving actual cash expenditures that affect the actual dollar income of the parent.

a. A person is self-employed when the person:
   (1) Is not required to report to the office regularly except for specific purposes such as sales training meetings, administrative meetings, or evaluation sessions.
   (2) Establishes the person’s own working hours, territory, and methods of work.
   (3) Files quarterly reports of earnings, withholding payments, and FICA payments to the Internal Revenue Service (IRS).

b. In calculating net income from self-employment, the child support recovery unit shall deduct only those items allowed by the child support guidelines. Amounts from a prior period claimed as net losses shall not be allowed as deductions.

c. Net profits from self-employment may be determined through a review of self-employment bookkeeping records, sales and expenditure records, quarterly reports filed with the IRS, previous year’s federal or state income tax returns, or other documentation. The parent shall provide records of
bookkeeping, sales, and expenditures for the most recent 12-month period or, if the self-employment is less than 12 months old, for the period since the self-employment began.

99.1(6) Fluctuating income. A person has a fluctuating income when the calculated gross income or the adjusted gross income, as defined in subrule 99.1(5), for the current year varies from the gross or adjusted gross income of the previous year by more than 20 percent.

a. If requested, the child support recovery unit shall average the income of a person whose income fluctuated because the nature of the person’s occupation is of a type that normally experiences fluctuations in income.

b. In determining a person’s average income, the following procedures shall be used:

(1) For non-self-employed persons, the child support recovery unit shall estimate the gross income for the current year and add the amount to the gross income from relevant years that would accurately depict fluctuations in the person’s income. The unit shall divide this sum by the number of years added, prior and current, to arrive at an average gross annual income. The unit shall divide the average gross annual income by 12 to arrive at the person’s average gross monthly income.

(2) For income from self-employment, the child support recovery unit shall compute the adjusted gross annual income as defined in subrule 99.1(5) for the relevant years that would accurately depict fluctuations in the person’s income. The unit shall use the adjusted gross annual income to compute the average adjusted gross monthly income in the same manner as the computation of average gross monthly income in 99.1(6)“b”(1).

441—99.2(234,252B) Allowable deductions. The deductions specified in the supreme court child support guidelines shall be allowed when determining the amount of income subject to application of the guidelines. The parent claiming the deduction shall provide the documentation necessary for computing allowable deductions. Allowable deductions are:

99.2(1) Federal and state income tax.

a. The child support recovery unit shall calculate the amount of the deduction for federal and state income tax as specified in the Iowa Supreme Court guidelines.

b. The unit shall calculate the amount of the deduction for self-employed persons with fluctuating incomes, as defined in subrule 99.1(6), by computing the person’s averaged income and applying the method of calculating a tax deduction as required by Iowa Supreme Court guidelines.

99.2(2) Social security and Medicare tax deductions, mandatory pensions, and union dues as specified in the Iowa Supreme Court guidelines.

99.2(3) Mandatory occupational license fees as specified in the Iowa Supreme Court guidelines.

99.2(4) Actual payments of child and spousal support pursuant to a prior court or administrative order. The date of the original court or administrative order, rather than the date of any modifications, shall establish a prior order under this subrule. Support paid under an order established subsequent to the order being modified shall not be deducted. All support payments shall be verified before being allowed as a deduction. The child support recovery unit shall calculate deductions for support as follows:

a. In establishing prior support payments, the child support recovery unit shall verify payments made for the 12 months preceding the month in which the amount of support for the new order is determined. If the support obligation is less than one year old, the child support recovery unit shall verify each monthly payment since the beginning of the obligation.

b. If the obligation is one year old or older, the child support recovery unit shall add together all verified amounts paid during the past 12 months up to the total of the current support obligation that accrued during this 12-month period, and divide by 12. All amounts collected shall be included, regardless of the source.

c. If the support obligation is less than one year old, the child support recovery unit shall add together the verified amounts paid since the obligation began up to the total of the current support obligation that accrued during this period, and divide by the number of months that the obligation has existed.
d. When a parent has more than one prior support order, the child support recovery unit shall calculate the allowable deduction for each obligation separately, and then add the amounts together to determine the parent’s total allowable deduction.

99.2(5) Actual medical support paid pursuant to a court order or administrative order in another order for other children, not the pending matter. All medical support payments shall be verified before being allowed as a deduction and shall be calculated in the same manner as the deductions for support in subrule 99.2(4).

99.2(6) Actual child care expenses during the custodial parent’s employment, less the applicable federal income tax credit. The child support recovery unit shall determine the amount of the child care deduction as follows:

a. Actual child care expenses related to the custodial parent’s employment shall be verified by a copy of the custodial parent’s federal or state income tax return or by a signed statement from the person or agency providing the child care.

b. Only the amount of reported child care expenses in excess of the amount allowed as “credit for child and dependent care expenses” for federal income tax purposes shall be allowed as a deduction in determining the custodial parent’s net income.

c. In determining the deduction allowed to the custodial parent for child care expenses due to employment, the following procedures shall be used:

(1) If the custodial parent provides a copy of a federal income tax return for the current tax processing year and the amount is consistent with the current financial circumstances of the parent, the child support recovery unit shall use the amount reported as “credit for child and dependent care expenses.”

(2) If income tax information is not available, or if the parent indicates or there is reason to believe that the amount stated in the return is no longer representative of the parent’s financial conditions or child care expenses, the child support recovery unit shall determine the allowable deduction for child care expenses for federal income tax purposes using the custodial parent’s income only.

d. The child support recovery unit shall compute the child care deduction as follows:

(1) Divide the amount of child care expense the parent may claim as a deduction for federal income tax purposes by 12 to arrive at a monthly amount.

(2) If the child care expense reported on the financial statement is not a monthly amount, convert the reported amount to an equivalent monthly figure and round the figure to two decimal places.

(3) Subtract the amount the parent may claim as “credit for child and dependent care expenses” for federal income tax from the amount of child care expenses reported on the financial statement. The difference is the amount allowed for a deduction in determining income for child support.

99.2(7) Qualified additional dependent deduction (QADD). The qualified additional dependent deduction is the amount specified in the supreme court guidelines as a deduction for any child for whom parental responsibility has been legally established as defined by the child support guidelines. However, this deduction may not be used for a child for whom the parent may be eligible to take a deduction under subrule 99.2(4).

a. The deduction for qualified additional dependents may be used:

(1) For dependents of the custodial or noncustodial father or mother, whether in or out of the parent’s home. The father may establish the deduction by providing written verification of a legal obligation to the children through one of the actions enumerated in the guidelines. The mother may establish the deduction by providing written verification of a legal obligation to the children, including the mother’s statement.

(2) In the establishment of original orders.

(3) In the modification of existing orders. The deduction may be used in an upward modification. The deduction cannot be used to affect the threshold determination of eligibility for a downward modification, but may be used after the threshold determination is met.

b. Reserved.

99.2(8) Cash medical support as specified in the Iowa Supreme Court guidelines.

[ARC 1357C, IAB 3/5/14, effective 5/1/14]
441—99.3(234,252B) Determining net income. Unless otherwise specified in these rules, the child support recovery unit shall determine net income as prescribed by the Iowa Supreme Court guidelines.

99.3(1) Calculating net income. All includable income and allowable deductions shall be expressed in monthly amounts. Income and corresponding deductions received at a frequency other than monthly shall be converted to equivalent monthly amounts by multiplying the income and corresponding deductions received on a weekly basis by 4.33, on a biweekly basis by 2.17, and on a semimonthly basis by 2.

99.3(2) Estimating net income.
   a. The estimated net income of a parent shall be 80 percent of the reported income or the estimated income as determined from occupational wage rate information or derived from the median income of parents on the CSRU caseload, as appropriate, minus the deductions enumerated in subrules 99.2(3) to 99.2(8) when the information to calculate these deductions is readily available through automated or other sources.
   b. The net income of a parent shall be estimated under the following conditions:
      (1) Gross earned income information was obtained from a source that did not provide itemized deductions allowed by the mandatory support guidelines.
      (2) Occupational wage rate information or median income of parents on the CSRU caseload was used to determine a parent’s income.

[ARC 1357C; IAB 3/5/14, effective 5/1/14]

441—99.4(234,252B) Applying the guidelines.

99.4(1) Applying the guidelines. The child support recovery unit shall use the child support guidelines schedule as prescribed by the Iowa Supreme Court only for the number of children for whom support is being sought sharing the same two legal parents.

   EXCEPTION: For foster care recovery cases, the guidelines schedule shall be used as set forth in subrule 99.5(4).

99.4(2) Establishing current support.
   a. Calculation. The child support recovery unit shall calculate the amount of support as prescribed by the Iowa Supreme Court guidelines. Round amount of support to the nearest whole dollar.
   b. Additional factors.
      (1) In all cases other than foster care, CSRU shall establish current support payable in monthly frequencies.
      (2) In foster care cases, CSRU may establish current support payable in monthly or weekly frequencies. To establish a weekly amount, CSRU shall divide the figure in paragraph 99.4(2) “a” by 4.33 and round to the nearest whole dollar.
      (3) If the court orders joint (equally shared) physical care of a child or split or divided physical care of multiple children, the unit shall calculate current support according to the Iowa Supreme Court guidelines for each parent assuming the other is the custodial parent. If a child begins receiving family investment program (FIP) benefits or if foster care funds are expended, an offset of the two amounts as a method of payment shall be disallowed.
      (4) The amount of support shall be zero if the noncustodial parent’s only income is Supplemental Security Income paid pursuant to 42 U.S.C. 1381a.

99.4(3) Establishing accrued support debt amount.
   a. Support debt created. The payment of public assistance to or for the benefit of a dependent child or a dependent child’s caretaker creates an accrued support debt due and owing by the child’s parent to the department. The amount of the accrued support debt is based on the period of time public assistance payment or foster care funds were expended, but is not created for the period of receipt of public assistance on the parent’s own behalf for the benefit of the dependent child or the child’s caretaker.
   b. Calculating accrued support debt. CSRU shall calculate the accrued support debt as follows:
      (1) For Family Investment Program (FIP) benefits, CSRU shall use the period for which FIP was paid during the 36 months preceding the date the notice of support debt is prepared or the date the petition is filed. For foster care assistance, CSRU shall use the three-month period for which foster care assistance
was paid prior to the date the initial notice to the noncustodial parent of the amount of support obligation is prepared, or the date a written request for a court hearing is received, whichever is earlier.

(2) CSRU shall exclude periods the noncustodial parent received public assistance as a part of this eligible group.

(3) CSRU may extend the period to include any additional periods public assistance is expended prior to the entry of the order.

(4) CSRU shall calculate the amount of the obligation by using the current net income of both parents, the guidelines in effect at the time the order is entered, and the number of children of the noncustodial parent who were receiving public assistance for each month for which accrued support is sought.

(5) CSRU shall calculate the total amount of the FIP support debt by multiplying the number of months for which assistance was paid times the determined guidelines amount.

(6) CSRU may calculate the total amount of the foster care support debt by multiplying the number of months for which assistance was paid times the determined guidelines amount and shall adjust this amount for weeks in which no foster care benefits were paid.

   c. Establishing the accrued support repayment amount.

   (1) In cases other than foster care, CSRU shall establish the repayment amount as follows:

      1. When there is an ongoing obligation, the monthly repayment amount shall be 10 percent of the ongoing amount unless the noncustodial parent agrees to a higher amount.

      2. When the order does not include ongoing support, the monthly repayment amount shall be the same as the amount for ongoing support which would have been due if such an obligation had been established. However, when all of the children for whom accrued support debt is sought are residing with the noncustodial parent, the monthly repayment amount shall be set at 10 percent of this amount.

   (2) In foster care cases, CSRU shall establish the repayment amount in the same manner as subparagraph (1), but may establish weekly amounts and if the order does not include ongoing support, the repayment amount shall be set at 10 percent of the amount for ongoing support which would have been due if such an obligation had been established.

99.4(4) Children in nonparental homes or foster care. The parents of a child in a nonparental home or in foster care are severally liable for the support of the child. A support obligation shall be established separately for each parent.

   a. Parents’ location known. When the location is known for both parents having a legal obligation to provide support for their children, the income of both parents shall be used to determine the amount of ongoing support in accordance with the child support guidelines.

      (1) Calculating support amount. There shall be a separate calculation of each parent’s child support amount, regardless of whether the parents are married and living together, or living separately. Each calculation shall assume that the parent for whom support is being calculated is the noncustodial parent and the other parent is the custodial parent.

      (2) Prior orders. If only one parent is paying support under a prior order for the children for whom support is being calculated, the amount of support paid shall not be deducted from that parent’s net monthly income in computing the support amount for the other parent.

   b. One parent’s location unknown. When the location of one parent is not known, procedures shall be initiated to establish a support order against the parent whose location is known in accordance with the mandatory support guidelines as follows:

      (1) The parent whose location is known shall be considered the noncustodial parent and that parent’s income shall be used to calculate child support.

      (2) The income of the parent whose location is unknown shall be determined by using the estimated median income for parents on the CSRU caseload and that parent shall be considered the custodial parent in calculating child support.

   c. When one parent is deceased or has had parental rights terminated, the method used to calculate support when one parent’s location is not known shall be used. The parent who is deceased or has had parental rights terminated shall be considered the custodial parent with zero income.
99.4(5) **Extraordinary visitation adjustment.** The extraordinary visitation adjustment is a credit as specified in the supreme court guidelines. The credit shall not reduce the child support below the amount required by the supreme court guidelines.

The extraordinary visitation adjustment credit shall be given if all of the following apply:

a. There is an existing order for the noncustodial parent that meets the criteria for extraordinary visitation in excess of 127 overnights per year on an annual basis for the child for whom support is sought. The order granting visitation can be a different order than the child support order. If a controlling order is determined pursuant to Iowa Code chapter 252K and that controlling support order does not meet the criteria for extraordinary visitation, there is another order that meets the criteria.

b. The noncustodial parent has provided CSRU with a file-stamped or certified copy of the order.

c. The court has not ordered equally shared physical care.

99.4(6) **Establishing medical support.** The child support recovery unit shall calculate medical support as required by Iowa Code chapter 252E and the Iowa Supreme Court guidelines. The cost of the health insurance premium for the child is added to the basic support obligation and prorated between the parents as provided in the Iowa Supreme Court guidelines, and the parent ordered to provide health insurance must provide verification of this expense or anticipated expense.

[ARC 1357C, IAB 3/5/14, effective 5/1/14]

441—99.5(234,252B) Deviation from guidelines.

99.5(1) **Criteria for deviation.** The court shall not vary from the amount of child support that would result from application of the guidelines without a written finding as required by the Iowa Supreme Court guidelines.

99.5(2) **Supporting financial and legal documentation.**

a. The party requesting a deviation from the guidelines shall provide supporting documentation. The supporting documentation shall include an itemized list identifying the amount and nature of each adjustment requested. Failure to provide supporting documentation for a request for deviation shall result in a denial of the request.

b. Legal documents prepared for the court’s approval, such as stipulations and orders for support, shall include language to identify the following:

   (1) The amount of support calculated under the guidelines without allowance for deviations.

   (2) The reasons for deviating from the guidelines.

   (3) The amount of support calculated after allowing for the deviation.

99.5(3) **Depreciation.** A parent may request a deduction for depreciation of machinery, equipment, or other property used to earn income. Straight-line depreciation shall be the only type of depreciation that shall be allowed as a deduction. The child support recovery unit shall allow the straight-line depreciation amount as a deduction if the parent provides documentation from a tax preparer verifying the amount of straight-line depreciation being claimed. Straight-line depreciation is computed by deducting the property’s estimated salvage value from the cost of the property, and deducting that figure in equal yearly amounts over the period of the property’s remaining estimated useful life.

99.5(4) **Foster care case.** In a foster care case, the child support recovery unit may deviate from the guidelines by applying a 30 percent flat rate deduction for parents who provide financial documentation. The flat rate deduction represents expenses under the case permanency plan and financial hardship allowances or other circumstances contemplated in Iowa Code section 234.39.

CSRU shall calculate the support obligation of the parents of children in foster care when the parents have a legal obligation for additional dependents in the home, as follows: The support obligation of each parent shall be calculated by allowing all deductions the parent is eligible for under the child support guidelines as provided in rule 441—99.2(234,252B) and by using the guidelines schedule corresponding to the sum of the children in the home for whom the parent has a legal obligation and the children in foster care. The calculated support amount shall be divided by the total number of children in foster care and in the home to compute the support obligation of the parent for each child in foster care.

99.5(5) **Negotiation of accrued support debt.** The child support recovery unit may negotiate with a parent to establish the amount of accrued support debt owed to the department. In negotiating accrued
support, the state does not represent the custodial parent. The custodial parent may intervene at any time prior to the filing of the order to contest the amount of the debt or request the entry of a judgment in the parent’s behalf which may otherwise be relinquished through negotiation or entry of a judgment.

[ARC 1357C, IAB 3/5/14, effective 5/1/14]

These rules are intended to implement Iowa Code sections 234.39, 252B.3, 252B.5, 252B.7A, and 598.21(4).

441—99.6 to 99.9 Reserved.

DIVISION II
PATERNITY ESTABLISHMENT
PART A
JUDICIAL PATERNITY ESTABLISHMENT

441—99.10(252A) Temporary support. If a court ordered a putative father to pay temporary support before entering an order making a final determination of paternity under Iowa Code section 252A.6A, but then the court determines that the putative father is not the legal father and enters an order terminating the temporary support, all the following apply.

99.10(1) Satisfaction of accrued support. Upon receipt of a file-stamped copy of the order terminating the support order, the child support recovery unit shall take the following action concerning unpaid support assigned to the department:

a. The child support recovery unit shall satisfy only unpaid support assigned to the department.

b. The child support recovery unit shall ask the obligee to sign the satisfaction acknowledging the obligee has no right to support owed the department and waive notice of hearing on a subsequent satisfaction order. If the obligee does not sign the satisfaction and waiver or notice, the child support recovery unit is not prevented from satisfying amounts due the department.

c. The child support recovery unit shall prepare the required documents to satisfy any amounts owed the department and shall file them with the appropriate district court.

99.10(2) Previously collected moneys. The child support recovery unit shall not return any moneys previously paid on the temporary support judgment.

This rule is intended to implement Iowa Code section 252A.6A.

441—99.11 to 99.20 Reserved.

PART B
ADMINISTRATIVE PATERNITY ESTABLISHMENT

441—99.21(252F) When paternity may be established administratively. The child support recovery unit may seek to administratively establish paternity and accrued or accruing child support and medical support obligations against an alleged father when the conditions specified in Iowa Code chapter 252F are met.

441—99.22(252F) Mother’s certified statement. Before initiating an action under Iowa Code chapter 252F, the unit may obtain a signed Child Support Information, Form 470-3877, or Establishment Questionnaire, Form 470-3929, or a similar document from the child’s caretaker. The unit shall obtain the Mother’s Written Statement Alleging Paternity, Form 470-3293, from the child’s mother certifying, in accordance with Iowa Code section 622.1, that the man named is or may be the child’s biological father. Government records, including but not limited to an application for public assistance, which substantially meet the requirements of Iowa Code section 622.1 may also be used. In signing Form 470-3293, the mother acknowledges that the unit may initiate a paternity action against the alleged father, and she agrees to accept service of all notices and other documents related to that action by first-class mail. The mother shall sign and return Form 470-3293 to the unit within ten days of the date of the unit’s request.

[ARC 1357C, IAB 3/5/14, effective 5/1/14]
441—99.23(252F) Notice of alleged paternity and support debt. Following receipt of the Mother’s Written Statement Alleging Paternity, Form 470-3293, or government records, including but not limited to an application for public assistance, which substantially meet the requirements of Iowa Code section 622.1, the unit shall serve a notice of alleged paternity and support debt as provided in Iowa Code section 252F.3.  
[ARC 1357C, IAB 3/5/14, effective 5/1/14]

441—99.24(252F) Conference to discuss paternity and support issues. The alleged father may request a conference as provided in Iowa Code section 252F.3, subsection (1), with the office that issued the notice to discuss paternity establishment and the amount of support he may be required to pay.

441—99.25(252F) Amount of support obligation. The unit shall determine the amount of the child support obligation accrued and accruing using the child support guidelines established by the Iowa Supreme Court, and pursuant to the provisions of Iowa Code section 252B.7A.

441—99.26(252F) Court hearing. If the alleged father requests a court hearing within the time frames specified in Iowa Code section 252F.3, or as extended by the unit, and paternity testing has not been conducted, the unit shall issue ex parte administrative orders requiring the alleged father, the mother and the child to submit to paternity testing.

441—99.27(252F) Paternity contested. The alleged father may contest the paternity establishment by submitting, within 20 calendar days after service of the notice upon him, as provided in rule 441—99.23(252F), a written statement contesting paternity to the address of the unit as set forth in the notice. The mother may contest paternity establishment by submitting, within 20 calendar days after the unit mailed her notice of the action or within 20 calendar days after the alleged father is served with the original notice, whichever is later, a written statement contesting paternity to the address of the unit as set forth in the notice. When paternity is contested, or at the unit’s initiative, the unit shall issue ex parte administrative orders requiring the alleged father, the mother and the child to submit to paternity testing. If the mother and child or children previously submitted blood or genetic specimens in a prior action to establish paternity against a different alleged father, the previously submitted specimens and prior results, if available, may be used for testing in this action.

441—99.28(252F) Paternity test results challenge. Either party or the unit may challenge the results of the paternity test by filing a written notice with the district court within 20 calendar days after the unit issues or mails the paternity test results to the parties. When a party challenges the paternity test results, and requests an additional paternity test, the unit shall order an additional blood or genetic test, if the party requesting the additional test pays for the additional testing in advance. If the party challenges the first paternity test results, but does not request additional tests, the unit may order additional blood or genetic tests.

441—99.29(252F) Agreement to entry of paternity and support order. If the alleged father admits paternity and reaches agreement with the unit on the entry of an order for support, the father may acknowledge his consent on the Child Support Declaration, Form 470-4084. If the mother does not contest paternity within the allowed time period or if the mother waives the time period for contesting paternity, the unit may file the Child Support Declaration, if applicable, and Administrative Paternity Order with the court in accordance with Iowa Code section 252F.6.

441—99.30(252F) Entry of order establishing paternity only. If the alleged father requests a court hearing on support issues and paternity is not contested, or if paternity was contested but neither party filed a timely challenge of the paternity test results, the unit shall prepare an order establishing paternity and reserving the support issues for determination by the court. The unit shall present the order and other
documents supporting the entry of the ex parte paternity-only order to the court for review and approval prior to the hearing on the support issues.

441—99.31(252F) Exception to time limit. The unit may accept and respond to written requests for court hearings beyond the time limits allowed in this part.

441—99.32(252F) Genetic test costs assessed.

99.32(1) Paternity established. If genetic testing of an alleged father is conducted and that man is established as the child’s father, the unit shall assess the costs of the genetic testing to the father who denied paternity and enter an order for repayment of these costs.

99.32(2) Paternity not established. If genetic testing of an alleged father is conducted and that man is not established as the child’s father, the costs of the genetic testing shall not be assessed to any of the parties.

99.32(3) Results contested. If the results of the genetic testing are timely challenged and the challenging party requests additional testing, the party contesting the results shall advance the cost of the additional testing. If the challenging party does not advance payment for the additional testing, the unit shall certify the case to district court.

These rules are intended to implement Iowa Code chapter 252F.

441—99.33 to 99.35 Reserved.

PART C
PATERNITY DISESTABLISHMENT

441—99.36(598,600B) Definitions.

“Disestablishment” means paternity which is legally overcome under the conditions specified in Iowa Code section 600B.41A or section 598.21, subsection 4A.

“Nonrequesting parent” means a parent who is not filing a petition to overcome paternity.

“Requesting parent” means a parent who files a petition to overcome paternity.

441—99.37(598,600B) Communication between parents. When a parent who has filed a petition to disestablish paternity requests assistance from the child support recovery unit in contacting the other parent, the child support recovery unit shall take the following actions if services are being provided by the child support recovery unit, the location of the nonrequesting party is known, and the child support recovery unit has been provided a copy of the petition to disestablish paternity.

99.37(1) Written contact. The child support recovery unit shall send written notification to the nonrequesting parent of the requesting parent’s desire to disestablish paternity and of the requesting parent’s whereabouts. The notice shall state that the nonrequesting parent may cooperate in this action by filing a statement of the nonrequesting parent’s current address or the name and address of the nonrequesting parent’s attorney in the court file, or may contact the requesting parent with this information.

99.37(2) Notification of requesting parent. The child support recovery unit shall provide notification to the requesting party that contact was made with the nonrequesting party and that the nonrequesting parent may file a statement in the court file or may contact the requesting parent directly.

441—99.38(598,600B) Continuation of enforcement. The child support recovery unit shall continue all enforcement actions to collect current and accrued support as ordered until the unit receives a file-stamped copy of the order disestablishing paternity.

441—99.39(598,600B) Satisfaction of accrued support.

99.39(1) Disestablishment orders entered before May 21, 1997. Upon receipt of a file-stamped copy of an order disestablishing paternity which was entered before May 21, 1997, the child support recovery unit shall take the following action concerning unpaid support assigned to the department.
a. The child support recovery unit shall satisfy only unpaid support assigned to the department and only if:
   (1) For actions under Iowa Code section 600B.41A, blood or genetic testing was done and a guardian ad litem was appointed for the child.
   (2) For actions under Iowa Code section 598.21, the written statement was filed and a guardian ad litem was appointed for the child.

   b. The child support recovery unit shall ask the obligee to sign the satisfaction acknowledging the obligee has no right to support owed the department and waive notice of hearing on a subsequent satisfaction order. If the obligee does not sign the satisfaction and waiver of notice, the child support recovery unit is not prevented from satisfying amounts due the department.

c. The child support recovery unit shall prepare the required documents to satisfy any amounts owed the department and shall file them with the appropriate district court. If the court later determines that paternity was incorrectly disestablished, the child support recovery unit may attempt to reinstate and enforce the prior judgment.

99.39(2) Disestablishment orders entered on or after May 21, 1997. Upon receipt of a file-stamped copy of an order disestablishing paternity which was entered on or after May 21, 1997, the child support recovery unit shall take the following action concerning unpaid support:
   a. If the order also contains a provision satisfying unpaid support, the unit shall adjust its records to show unpaid support is paid.
   b. If the order does not contain a provision satisfying unpaid support, the unit shall satisfy only unpaid support assigned to the department. The unit shall notify the party who petitioned the court for disestablishment that this is the only support the unit can satisfy.

   (1) The child support recovery unit shall ask the obligee to sign the satisfaction acknowledging the obligee has no right to support owed the department and waive notice of hearing on a subsequent satisfaction order. If the obligee does not sign the satisfaction and waiver notice, the child support recovery unit is not prevented from satisfying amounts due the department.
   (2) The child support recovery unit shall prepare the required documents to satisfy any amounts owed the department and shall file them with the appropriate court. If the court later determines that paternity was incorrectly disestablished, the child support recovery unit may attempt to reinstate and enforce the prior judgment.

99.39(3) Termination of paternity. If the court entered an order dismissing a disestablishment of paternity action on or before May 21, 1997, this subrule applies. Upon receipt of a file-stamped copy of an order terminating paternity under the requirements of Iowa Code section 600B.41A, the child support recovery unit shall take the following action concerning unpaid support assigned to the department:
   a. The child support recovery unit shall satisfy only unpaid support assigned to the department.
   b. The child support recovery unit shall ask the obligee to sign the satisfaction acknowledging the obligee has no right to support owed the department and waive notice of hearing on a subsequent satisfaction order. If the obligee does not sign the satisfaction and waiver of notice, the child support recovery unit is not prevented from satisfying amounts due the department.
   c. The child support recovery unit shall prepare the required documents to satisfy any amounts owed the department and shall file them with the appropriate district court. If the court later determines that paternity was incorrectly terminated, the child support recovery unit may attempt to reinstate and enforce the prior judgment.

99.39(4) Previously collected moneys. The child support recovery unit shall not return any moneys previously paid on the judgment.

These rules are intended to implement Iowa Code section 598.21, subsection 4A, and Iowa Code section 600B.41A.

441—99.40 Reserved.
DIVISION III
ADMINISTRATIVE ESTABLISHMENT OF SUPPORT
[Prior to 9/1/93, see 441—95.11(252C)]

441—99.41(252C) Establishment of an administrative order.

99.41(1) When order may be established. The bureau chief may establish a child or medical support obligation against a responsible person through the administrative process. This does not preclude the child support recovery unit from pursuing the establishment of an ongoing support obligation through other available legal proceedings. When gathering information to establish a support order, the unit may obtain a signed Child Support Information, Form 470-3877, or Establishment Questionnaire, Form 470-3929, or a similar document from the child’s caretaker.

99.41(2) Support debt. When public assistance is paid to or Medicaid is received by a child of the responsible person, or the dependent child’s caretaker, a support debt is created and owed to the department. When no public assistance is paid or Medicaid is received, the debt is owed to the individual caretaker.

99.41(3) Notice to responsible person. When the bureau chief establishes a support debt against a responsible person, a notice of child support debt shall be served in accordance with the Iowa Rules of Civil Procedure or Iowa Code section 252B.26. The notice shall include all of the rights and responsibilities shown in Iowa Code section 252C.3. The notice shall also inform the responsible person which of these rights may be waived pursuant to Iowa Code section 252C.12, and the procedures for and effect of waiving these rights. The notice shall include a statement that failure to respond within the time limits given and to provide information and verification of financial circumstances shall result in the entry of a default judgment for support.

99.41(4) Negotiation conference. The responsible person may, within ten calendar days after being served the notice of child support debt, request a negotiation conference with the office of the child support recovery unit which sent the notice.

99.41(5) Amount of support obligation. The child support recovery unit shall determine the amount of the child support obligation accrued and accruing using the child support guidelines established by the Iowa Supreme Court, and pursuant to the provisions of Iowa Code section 252C.7A.

a. Any deviation from the guidelines shall require a written finding by the bureau chief.

b. Reserved.

99.41(6) Reserved.

99.41(7) Court hearing. Either the responsible person or the child support recovery unit may request a court hearing regarding the establishment of a support obligation through the administrative process.

a. The request for a hearing by the responsible person shall be in writing and sent to the office of the child support recovery unit which sent the original notice of the support debt by the latest of the following:

(1) Thirty days from the date of service of the first notice of support debt.

(2) Ten days from the date of the negotiation conference.

(3) Thirty days from the date the second notice and finding of financial responsibility is issued.

(4) Ten days from the date of issuance of the conference report if the bureau chief does not issue a second notice and finding of financial responsibility after a conference was requested.

b. When a request for a court hearing is received from the responsible person, within the time limits allowed, or is made by the child support recovery unit, the bureau chief shall schedule or request that the hearing be scheduled in the district court in the county:

(1) Where the dependent child resides if the child resides in Iowa.

(2) Where the responsible person resides if the child for whom support is sought resides in another state or the sole purpose of the administrative order is to secure a judgment for the time period that public assistance was expended by the state on behalf of the family or child.

99.41(8) Exception to time limit. The bureau chief may accept and respond to written requests for a court hearing beyond the time limits allowed in this rule.
99.41(9) **Entry of order.** If no request for a hearing is received from the responsible person at the local office of the child support recovery unit, or made by the unit, the bureau chief may prepare an order for support and have it presented ex parte to the court for approval.

a. The attorney for the child support recovery unit shall present the order and other documents supporting the entry of the ex parte order to the court for review and approval. Pursuant to Iowa Code chapter 252C, the court shall approve the order unless defects appear in the order or supporting documents.

b. The bureau chief shall file a copy of the approved order with the clerk of the district court.

c. The bureau chief shall send a copy of the filed order by regular mail, to the caretaker’s last-known address, to the responsible person’s last-known address or the caretaker’s or the responsible person’s attorney pursuant to the provisions of Iowa Code chapter 252C within 14 days after approval and issuance of the order by the court.

99.41(10) **Force and effect.** Once the order has been signed by the judge and filed, it shall have all the force and effect of an order or decree entered by the court. Unless otherwise specified, the effective date of the support obligation shall be the twentieth day following the date the order is prepared by the unit.

99.41(11) **Modification by bureau chief.** The bureau chief may petition an appropriate court for modification of a court order on the same grounds as a party to the court order can petition the court for modification.

This rule is intended to implement Iowa Code chapter 252C.

[ARC 1357C, IAB 3/5/14, effective 5/1/14]

441—99.42 to 99.60 **Reserved.**

DIVISION IV

**REVIEW AND ADJUSTMENT OF CHILD SUPPORT OBLIGATIONS**

[Prior to 9/1/93, see 441—98.51(73GA,ch1244) to 98.60(73GA,ch1244)]

441—99.61(252B,252H) **Definitions.**

“Guidelines” means the most current guidelines and criteria prescribed by the Iowa Supreme Court for determining the amount of child support to be awarded.

“Parent” means a person who is a responsible person or a caretaker, as those terms are defined in rule 441—95.1(252B).

“Recipient of service” means a person receiving foster care services, or a recipient of family investment program assistance or Medicaid benefits whose child support or medical support is assigned, or a person who is not receiving public assistance but who is entitled to child support enforcement services pursuant to Iowa Code section 252B.4.

441—99.62(252B,252H) **Review of permanent child support obligations.** Permanent child support obligations that are ongoing and being enforced by the child support recovery unit or the child support agency of another state shall be reviewed by the unit to determine whether or not to adjust the obligation. The unit shall determine the appropriate obligation amount using the child support guidelines. Iowa must have continuing, exclusive jurisdiction to modify the order under Iowa Code chapter 252K.

99.62(1) **Periodic review.** A permanent child support obligation being enforced by the child support recovery unit and meeting the conditions in Iowa Code section 252H.12 may be reviewed upon the initiative of the unit if:

a. The right to any ongoing child support obligation is currently assigned to the state due to the receipt of public assistance.

b. The support order does not already contain medical support provisions.

c. A review is otherwise necessary to comply with state or federal law.

99.62(2) **Review by request.** A review shall be conducted upon the request of the child support recovery agency of another state or upon the written request of either parent subject to the order submitted on Form 470-2749, Request to Modify a Child Support Order. One review may be conducted every two
years when the review is being conducted at the request of either parent. The request for review may be no earlier than two years from the filing date of the support order or most recent modification or the last completed review, whichever is later.

   a. Procedures to adjust the support obligation shall be initiated only when the financial and other information available to the child support recovery unit indicates that the:
      (1) Present child support obligation varies from the Iowa Supreme Court mandatory child support guidelines by more than 20 percent, and
      (2) Variation is due to a change in financial circumstances which has lasted at least three months and can reasonably be expected to last for an additional three months.
   b. Procedures to modify a support order may be initiated when the order does not include provisions for medical support.

[ARC 9352B, IAB 2/9/11, effective 4/1/11]

441—99.63(252B,252H) Notice requirements. The child support recovery unit shall provide written notification to each parent affected by a permanent child support obligation being enforced by the child support recovery unit as follows:

99.63(1) Notice of right to request review. The child support recovery unit shall notify each parent of the right to request review of the order and the appropriate place and manner in which the request should be made. Notification shall be provided on Form 470-0188, Application For Nonassistance Support Services, or Form 470-1981, Notice of Continued Support Services, or through another printed or electronic format.

99.63(2) Notice of review. One of the following shall apply:
   a. At least 15 days before the review is conducted, the child support recovery unit shall serve notice of its intent to review the order on each parent affected by the child support obligation. This notice shall include a request that the parties complete a financial statement and provide verification of income. The notice shall be served in accordance with Iowa Code section 252B.26 or 252H.15.
   b. If the conditions of Iowa Code section 252H.14A(1) are met, the unit may conduct a review using information accessible to the unit without:
      (1) Issuing a notice under paragraph 99.63(2)”a,” or
      (2) Requesting additional information from the parent.

99.63(3) Notice of decision. After the child support recovery unit completes the review of the child support obligation in accordance with rule 441—99.62(252B,252H), the unit shall issue a notice of decision in accordance with Iowa Code section 252H.14A or 252H.16 stating whether or not an adjustment is appropriate and, if so, the unit’s intent to enter an administrative order for adjustment.
   a. and b. Rescinded IAB 2/5/03, effective 4/1/03.

99.63(4) Challenges to outcome of review. Each parent shall be allowed to request a second review challenging the determination of the child support recovery unit. The procedure for challenging the determination is as follows:
   a. The parent challenging the determination shall submit the request for a second review in writing to the child support recovery unit stating the reasons for the request and providing written evidence necessary to support the challenge. The request must be submitted:
      (1) Within 10 days from the date of a notice of decision issued pursuant to Iowa Code section 252H.16, or
      (2) Within 30 days from service of a notice of decision issued pursuant to Iowa Code section 252H.14A.
   b. The child support recovery unit shall review the written evidence submitted with the request and all financial information available to the unit and make a determination of one of the following:
      (1) Rescinded IAB 2/5/03, effective 4/1/03.
      (2) To enter an administrative order for adjustment of the obligation.
      (3) That adjustment of the child support obligation is inappropriate.
c. The unit shall send written notice of the outcome of the second review to each parent affected by the child support obligation at the parent’s last-known mailing address.

d. For a review initiated under Iowa Code section 252H.15, if either parent disputes the second decision, the objecting parent may request a court hearing within 15 days from the date the notice of decision is issued or within 10 days of the date the second notice of decision is issued, whichever is later.

e. For a review initiated under Iowa Code section 252H.14A, either parent may request a court hearing within 10 days of the issuance of the second notice of decision.

f. If the unit receives a timely written request or the unit determines that a court hearing is necessary, the unit shall certify the matter to the district court. An objecting parent may seek recourse by filing a private petition for modification through the district court.

[ARC 9352B, IAB 2/9/11, effective 4/1/11; ARC 4576C, IAB 7/31/19, effective 9/4/19]

441—99.64(252B,252H) Financial information. The child support recovery unit shall attempt to obtain and verify information concerning the financial circumstances of the parents subject to the order to be reviewed necessary to conduct the review.

99.64(1) Financial statements. Except for a review initiated under Iowa Code section 252H.14A, both parents subject to the order to be reviewed shall provide a financial statement and verification of income within ten days of service of the notice of the unit’s intent to review the obligation. If a review is initiated under Iowa Code section 252H.14A and the first notice of decision is challenged as described in subrule 99.63(4), both parents shall be requested to provide a financial statement and verification of income within ten days of the unit’s request.

a. Verification of income shall include, but not be limited to, the following: copies of state and federal income tax returns, W-2 statements, pay stubs, or a signed statement from an employer or other source of income.

b. The child support recovery unit may also request that the parent requesting review provide an affidavit regarding the financial circumstances of the nonrequesting parent when the unit is otherwise unable to obtain financial information concerning the nonrequesting parent. The requesting parent shall complete the affidavit if the parent possesses sufficient information to do so.

99.64(2) Independent sources. The child support recovery unit may utilize other resources to obtain or confirm information concerning the financial circumstances of the parents subject to the order to be reviewed.

a. These resources include, but are not limited to, the following: the Iowa workforce development department, the Iowa department of revenue, the Internal Revenue Service, the employment, revenue, and child support recovery agencies of other states, and the Social Security Administration.

b. In the absence of other verification of income and deductions allowed under the mandatory support guidelines, the child support recovery unit may estimate the net earned income of a parent for the purpose of determining the amount of support that would be due under the guidelines by deducting 20 percent from the gross earned income confirmed by an independent source. A parent may challenge this estimate by providing verification of actual earned income deductions.

99.64(3) Availability of medical insurance. Both parents subject to the order to be reviewed shall provide documentation regarding the availability of health insurance coverage for the children covered under the order, and the cost of the coverage, within ten days of a written request by the child support recovery unit. Verification may include, but not be limited to: a copy of the health benefit plan including the effective date of the plan, a letter from the employer detailing the availability of health insurance, or any other source that will serve to verify health insurance information and the cost of the coverage.

[ARC 9352B, IAB 2/9/11, effective 4/1/11]

441—99.65(252B,252H) Review and adjustment of a child support obligation.

99.65(1) Conducting the review. The child support recovery unit or its attorney shall review the case for administrative adjustment of a child support obligation unless it is determined that any of the following exist:

a. The location of one or both of the parents is unknown.
b. The variation from the Iowa Supreme Court mandatory child support guidelines is based on any material misrepresentation of fact concerning any financial information submitted to the child support recovery unit.

c. The criteria of rule 441—99.62(252B,252H) are not met.

d. The end date of the order is less than 12 months in the future or the youngest child is 17 ½ years of age.

99.65(2) Civil action. The review and adjustment action that is certified to court for hearing shall proceed as an ordinary civil action in equity, and the child support recovery unit attorney shall represent the state of Iowa in those proceedings.

99.65(3) Private counsel. After the notice has been issued as described in subrule 99.63(2) or 99.63(3), any party may choose to be represented personally by private counsel. Any party who retains private counsel shall notify the child support recovery unit of this fact in writing.

[ARC 9352B, IAB 2/9/11, effective 4/1/11; ARC 3719C, IAB 3/28/18, effective 7/1/18]

441—99.66(252B,252H) Medical support. The child support recovery unit, or its attorney, shall review the medical support provisions contained in any permanent child support order which is subject to review under rule 441—99.65(252B,252H) and shall include in any adjustment order a provision for medical support as defined in Iowa Code chapter 252E, and as set forth in 441—Chapter 98, Division I, or other appropriate provisions pertaining to medical support for all children affected directly by the child support order under review.

[ARC 9352B, IAB 2/9/11, effective 4/1/11]

441—99.67(252B,252H) Confidentiality of financial information. Financial information provided to the child support recovery unit by either parent for the purpose of facilitating the review and adjustment process may be disclosed to the other parties to the case, or to the district court, as follows:

99.67(1) Financial statements. Statements of financial status may be disclosed to either party.

99.67(2) Other documentation. Supporting financial documentation such as state and federal income tax returns, pay stubs, IRS Form W-2, bank statements, and other written evidence of financial status may be disclosed to the court after the notice has been issued as described in subrule 99.63(2) or 99.63(3), unless otherwise prohibited by state or federal law.

[ARC 9352B, IAB 2/9/11, effective 4/1/11]

441—99.68(252B,252H) Payment of service fees and other court costs. Payment of fees for administrative review or service of process and other court costs associated with the review and adjustment process is the responsibility of the party requesting review unless the court orders otherwise or the requesting party, as a condition of eligibility for receiving public assistance benefits, has assigned the rights to child or medical support for the order to be modified.

A requesting party who is indigent or receiving public assistance may request deferral of fees and costs. For the purposes of the division, “indigent” means that the requesting party’s income is 200 percent or less than the poverty level for one person as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

441—99.69(252B,252H) Denying requests. A request for review by a parent subject to the order may be denied for the following reasons:

99.69(1) Rescinded IAB 8/2/95, effective 10/1/95.

99.69(2) It has been less than two years since the support order was filed with the court, last modified, or last reviewed for the purpose of adjustment.

99.69(3) The child support recovery unit or a child support agency of another state is not providing enforcement services for an ongoing support obligation under the order for which the review has been requested.

99.69(4) The request is based entirely on issues such as custody or visitation rights, which are not directly related to child support.
99.69(5) The request is for the sole purpose of modifying the amount of delinquent support that has accrued under a support order.
99.69(6) The request is for the review of a temporary support order.

441—99.70(252B,252H) Withdrawing requests. If the requesting party contacts the child support recovery unit to withdraw the request, the child support recovery unit shall proceed as follows:

99.70(1) Best interests of the child. Rescinded IAB 2/5/03, effective 4/1/03.
99.70(2) Consent of both parties. The child support recovery unit shall notify the nonrequesting party of the requesting party’s desire to withdraw the request.
   a. If the nonrequesting party indicates a desire to continue the review, the unit shall proceed with the review and adjust the obligation, if appropriate.
   b. If the nonrequestor indicates a desire to stop the process or fails to respond within ten days to the notification of the request to withdraw, the unit shall notify all parties that the review and adjustment process has been terminated.
99.70(3) Effect of withdrawal. If a request is successfully withdrawn pursuant to subrule 99.70(2), a later request by either party shall be subject to the limitations of subrule 99.62(2).

441—99.71(252H) Effective date of adjustment. Unless subject to court action or reconciliation of multiple Iowa orders, the new obligation amount shall be effective on the first date that the periodic payment is due under the order being modified after the unit files the adjustment order with the court.

These rules are intended to implement Iowa Code sections 252B.5 to 252B.7 and 598.21C(2) and Iowa Code chapter 252H.

441—99.72 to 99.80 Reserved.

DIVISION V
ADMINISTRATIVE MODIFICATION

PREAMBLE

This division implements those provisions of Iowa Code chapter 252H which provide for administrative modification of support obligations when there is a substantial change in the financial circumstances of a party and when both parties agree to a change in an obligation through a cost-of-living alteration. These rules also provide for use of the administrative procedure to modify orders to add children, correct errors, set support which had previously been reserved or set at zero dollars, and increase support for minor obligors who do not comply with statutory educational or parenting class requirements or who are no longer minors.

441—99.81(252H) Definitions.

“Additional child” means a child to be added to an existing support order covering another child of the same parents.

“Born of a marriage” means a child was born of a woman who was married at the time of conception, birth, or at any time during the period between conception and birth of the child pursuant to Iowa Code chapter 252A and Iowa Code section 144.13.

“Cost-of-living alteration” means a change in an existing child support order that equals an amount which is the amount of the support obligation following application of the percentage change of the consumer price index for all urban consumers, United States city average, as published in the Federal Register by the federal Department of Labor, Bureau of Labor Statistics, pursuant to Iowa Code section 252H.2.

“Guidelines” means the most current guidelines and criteria prescribed by the Iowa Supreme Court for determining the amount of child support to be awarded.

“Parent” means a person who is a responsible person or a caretaker, as those terms are defined in rule 441—95.1(252B).

“Substantial change of circumstances,” for the purposes of this division, means:
1. There has been a change of 50 percent or more in the net income of a parent, as determined by comparing the new net income with the net income upon which the current child support obligation was based, and
2. The change is due to financial circumstances which have existed for a minimum period of three months and can reasonably be expected to exist for an additional three months, pursuant to Iowa Code section 252H.18A.

441—99.82(252H) Availability of service. The child support recovery unit shall provide the services described in this division for a support order originally entered or a foreign order registered in the state of Iowa. The order must be one which:
1. Involves at least one child born of a marriage or one child for whom paternity has been legally established.
2. Is being enforced by the unit in accordance with Iowa Code chapter 252B.
3. Is subject to the jurisdiction of this state for the purposes of modification.
4. Is not subject to or is not appropriate for review and adjustment.
5. Provides for support of at least one child under the age of 18 or a child between the ages of 18 and 19 years who is engaged full-time in completing high school graduation or equivalency requirements in a manner which is reasonably expected to result in completion of the requirements prior to the person’s reaching 19 years of age.
6. Has an obligation ending more than 12 months in the future.
7. Involves parents for whom the location of both parents is known.

441—99.83(252H) Modification of child support obligations. Permanent child support obligations meeting the criteria set forth in rule 441—99.82(252H) may be modified at the initiative of the unit, or upon written request of either parent subject to the order submitted on Form 470-2749, Request to Modify a Child Support Order. Any action shall be limited to adjustment, modification, or alteration of the child support or medical provisions of the support order. The duration of the underlying order shall not be modified. The procedures used by the child support recovery unit to determine if a modification is appropriate are as follows:

99.83(1) Substantial change of circumstances. Procedures to modify the support obligation may be initiated outside the minimum time frame described in subrule 99.62(2) if a request is received from either parent and if the parent has submitted verified documentation of a substantial change in circumstances which indicates both of the following:
   a. A change of at least 50 percent in the net income of a parent as defined by guidelines. The new net income will be compared to the net income upon which the current child support obligation was based.
   b. The change is due to financial circumstances which have existed for a minimum period of three months and can reasonably be expected to exist for an additional three months.

   The unit shall review the request and documentation and, if appropriate, issue a notice of intent to modify as described in subrule 99.84(1).

99.83(2) Adding provisions for additional children. Procedures to modify the support obligation may be initiated if:
   a. A parent requests, in writing, or the unit determines that it is appropriate to add an additional child to the support order and modify the obligation amount according to the guidelines pursuant to Iowa Code section 598.21B and Iowa Code section 252B.7A; and
   b. Paternity has been legally established.

   When adding a child to an order through administrative modification, medical support provisions shall apply to the additional child.

99.83(3) Reserved, zero-dollar-amount, or medical-provisions-only orders. Procedures to modify the support obligation may be initiated if:
   a. A parent requests a modification in writing or the unit determines that it is appropriate to include a support amount based on the guidelines; and
b. The original order:
   (1) Reserved establishment of an ongoing, dollar-amount support obligation giving a specific reason other than lack of personal jurisdiction over the obligor, or
   (2) Set the amount at zero, or
   (3) Was for medical provisions only.

99.83(4) Corrections. Procedures to modify the support obligation may be initiated if:
   a. An error or omission pertaining to child support or medical provisions was made during preparation or filing of a support order; and
   b. A necessary party requests a modification or the unit determines that a modification to correct an error or omission is appropriate.

99.83(5) Noncompliance by minor obligors. The unit may initiate procedures to modify a support order if a parent requests modification in writing or the unit determines that it is appropriate when:
   a. An obligor who is under 18 years of age fails to comply with the requirement to attend parenting classes pursuant to Iowa Code section 598.21G; or
   b. An obligor who is 19 years of age or younger fails to provide proof of compliance with education requirements described in Iowa Code section 598.21B(2)“e”; or
   c. The obligor no longer meets the age requirements as defined in Iowa Code section 598.21B(2)“e” or 598.21G.

99.83(6) Cost-of-living alteration. A support order may be modified to provide a cost-of-living alteration if all the following criteria are met:
   a. A parent requests a cost-of-living alteration in writing.
   b. At least two years have passed since the order was filed with the court or last reviewed, modified, or altered.
   c. The nonrequesting parent signs a statement agreeing to the cost-of-living alteration of the support order.
   d. Each parent signs a waiver of personal service accepting service by regular mail.
   e. The current support order addresses medical support for the children.
   f. A copy of each affected order is provided, if the unit does not already have copies in its files.

[ARC 9352B, IAB 2/9/11, effective 4/1/11; ARC 1357C, IAB 3/5/14, effective 5/1/14]

441—99.84(252H) Notice requirements. The child support recovery unit shall provide written notification to parents affected by a permanent child support obligation being enforced by the unit as follows:

99.84(1) Notice of intent to modify. When a request for administrative modification is received or the unit initiates an administrative modification, the unit shall provide written notice to each parent of its intent to modify.
   a. The notice shall include the legal basis and purpose for the action; a request for income or other information necessary for the application of guidelines (if applicable); an explanation of the legal rights and responsibilities of the affected parties, including time frames; and procedures for contesting the action.
   b. The unit shall take the following actions to notify parents:
      (1) Rescinded IAB 2/5/03, effective 4/1/03.
      (2) If the modification is based on subrules 99.83(1) through 99.83(5), notice shall be provided to each parent. The notice shall be served in accordance with the Iowa Rules of Civil Procedure or Iowa Code section 252B.26 or 252H.19.
      (3) If the modification is based on provision of a cost-of-living alteration as established at subrule 99.83(6) and the required documentation is included, the child support recovery unit shall notify each parent of the amount of the cost-of-living alteration by regular mail to the last-known address of each parent or, if applicable, each parent’s attorney. The notice shall include:
         1. The method of determining the amount of the alteration pursuant to Iowa Code section 252H.21.
         2. The procedure for contesting a cost-of-living alteration by making a request for review of a support order as provided in Iowa Code section 252H.24.
3. A statement that either parent may waive the 30-day notice waiting period. If both parents waive the notice waiting period, the unit may prepare an administrative order altering the support obligation.

99.84(2) Notice of decision to modify. The unit shall issue a notice of its decision to modify the support order to each parent affected by the support obligation at each parent’s (or attorney’s) last-known address. The notice shall contain information about whether the unit will continue or terminate the action and the procedures and timelines for contested action in accordance with 441—subrule 99.86(2).

[ARC 9352B, IAB 2/9/11, effective 4/1/11]

441—99.85(252H) Financial information. The child support recovery unit may attempt to obtain and verify information concerning the financial circumstances of the parents subject to the order to be modified that is necessary to conduct an analysis and determine support. The unit does not require financial information if the request is for a cost-of-living alteration.

99.85(1) Financial statements. Parents subject to the order shall provide a financial statement and verification of income within ten days of a written request by the unit.

a. If the modification action is based on a substantial change of circumstances:

(1) The requesting party must provide Form 470-2749, Request to Modify a Child Support Order, and documentation that proves the amount of change in net income and the date the change took place, such as:

   1. Copies of state and federal income tax returns, W-2 statements, or pay stubs, or
   2. A signed statement from an employer or other source of income.

(2) The unit shall review the request and documentation. If appropriate, the unit shall issue to each parent a notice of intent to modify the order as stated in subrule 99.84(1) and a financial statement. Each parent shall complete and sign the financial statement and return it to the unit with verification of income and deductions as described in subrule 99.1(3).

b. The unit may require a completed and signed financial statement and verification of income from each parent as described in subrule 99.1(3) if the modification is based on:

(1) Addition of a child;
(2) Changing a reserved or zero-dollar-amOUNT obligation;
(3) Changing a medical-provisions-only obligation;
(4) Making a correction (if financial information is needed); or
(5) Noncompliance by a minor obligor as defined in Iowa Code section 598.21B(2)“e” or 598.21G.

c. The unit may also request that a parent requesting a modification provide an affidavit regarding the financial circumstances of the nonrequesting parent when the unit is otherwise unable to obtain financial information concerning the nonrequesting parent. The requesting parent shall complete the affidavit if the parent possesses sufficient information to do so.

d. The unit may also use the most recent wage rate information published by the department of workforce development or the median income for parents on the unit caseload to estimate the net earned income of a parent when a parent has failed to return a completed financial statement when requested and complete and accurate information is not readily available from other sources.

e. Self-employment income will be determined as described in subrule 99.1(5).

99.85(2) Independent sources. The child support recovery unit may use other sources to obtain or confirm information concerning the financial circumstances of the parents subject to the order to be modified as described in rule 441—99.1(234,252B).

99.85(3) Guidelines calculations.

a. The unit shall determine:

(1) The appropriate amount of the child support obligation (excluding cost-of-living alteration amounts) as described in rules 441—99.1(234,252B) through 441—99.5(234,252B), and
(2) Medical support provisions as described in Iowa Code chapter 252E and rules 441—98.1(252E) through 441—98.7(252E).

b. If the modification action is due to noncompliance by a minor obligor, as defined in Iowa Code section 598.21B(2)“e” or 598.21G, the unit will impute an income to the obligor equal to a 40-hour
workweek at the state minimum wage unless the parent’s education, experience, or actual earnings justify a higher income.

[ARC 9352B, IAB 2/9/11, effective 4/1/11]

441—99.86(252H) Challenges to the proposed modification action. For modification actions based on subrules 99.83(1) through 99.83(5), each parent shall have the right to request a conference to contest the proposed modification. Either parent, or the unit, may also request a court hearing. For requests made based on subrule 99.83(6), either parent may contest the cost-of-living alteration by making a request for a review and adjustment of the support order.

99.86(1) Conference. Either parent may contest the proposed modification based on subrules 99.83(1) through 99.83(5) by means of a conference with the office of the unit that issued the notice of intent to modify.

a. Only one conference shall be held per parent.

b. The request must be made within ten days of the date of service of the notice of intent to modify.

c. The office that issued the notice of intent to modify shall schedule a conference with the parent and advise the parent of the date, time, place, and procedural aspects of the conference.

d. Reasons for contesting the modification include, but are not limited to, mistake of fact regarding the identity of one of the parties or the amount or terms of the modification.

e. The child support recovery unit may conduct the conference in person or by telephone.

f. If the party who requested the conference fails to attend the conference, only one alternative time shall be scheduled by the child support recovery unit.

g. The results of a conference shall in no way affect the right of either party to request a court hearing pursuant to subrule 99.86(2).

h. Upon completion of the conference, the unit shall issue a notice of decision to modify as described in subrule 99.84(2).

99.86(2) Court hearing.

a. Either parent, or the unit, may contest the proposed modification, based on subrules 99.83(1) through 99.83(5), by requesting a court hearing within the latest of any of the following time periods:

(1) Twenty days from the date of successful service of the notice of intent to modify,

(2) Ten days from the date scheduled for a conference, or

(3) Ten days from the date of issuance of a notice of decision to modify.

b. If the unit receives a timely written request, the unit shall certify the matter to the district court as described in Iowa Code section 252H.8.

c. If a timely request is not received, if waiting periods have been waived, or if the notice periods have expired, the unit shall prepare an administrative order as provided in Iowa Code section 252H.9.

99.86(3) Contesting a proposed cost-of-living alteration. Either parent may contest a cost-of-living alteration within 30 days of the date of the notice of intent to modify by making a request for a review of the support order as provided in Iowa Code section 252H.13.

a. If the unit receives a timely written request for review, the unit shall terminate the cost-of-living alteration process and proceed with the review and adjustment process.

b. If a timely request is not made, or the notice waiting period has been waived by both parties, or the notice period has expired, the unit shall prepare an administrative order as provided in Iowa Code section 252H.24.

441—99.87(252H) Misrepresentation of fact.

99.87(1) The unit shall not modify the support order based on a substantial change of circumstances if a change in income is due to any material misrepresentation of fact concerning any financial information submitted to the child support recovery unit.

99.87(2) The unit may request verification that all facts concerning financial information are true. Verification may include, but is not limited to, a statement from the employer, a doctor, or other person with knowledge of the situation.

[ARC 3719C, IAB 3/28/18, effective 7/1/18]
441—99.88(252H) Effective date of modification. Unless subject to court action or reconciliation of multiple Iowa orders, the new obligation shall be effective on the first date that the periodic payment is due under the order being modified after the unit files the modification order with the court. If the modification is based on a reserved, zero-dollar-amount, or medical-provisions-only obligation, the new obligation shall be effective 20 days after generation of the administrative modification order.

441—99.89(252H) Confidentiality of financial information. Financial information provided to the child support recovery unit by either parent for the purpose of facilitating the modification process may be disclosed to the other parties to the case, or the district court, as follows:

99.89(1) Financial statements. The financial statement or affidavit may be disclosed to either party.

99.89(2) Other documentation. Supporting financial documentation such as state and federal income tax returns, paycheck stubs, IRS Form W-2, bank statements, and other written evidence of financial status may be disclosed to the court unless otherwise prohibited by state or federal law.

441—99.90(252H) Payment of fees. Payment of service of process and other costs associated with the modification process is the responsibility of the party requesting modification unless the court orders otherwise or the requesting party, as a condition of eligibility for receiving public assistance benefits, has assigned the rights to child or medical support for the order to be modified.

A requesting party who is indigent or receiving public assistance may request deferral of fees and costs. For the purposes of this division, “indigent” means that the requesting party’s income is 200 percent or less than the poverty level for one person as defined by the United State Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

441—99.91(252H) Denying requests. A request for modification by a parent subject to the order may be denied if the criteria in rule 441—99.82(252H) are not met or the following conditions exist:

99.91(1) Nonsupport issues. The request is based entirely on issues such as custody or visitation rights.

99.91(2) Request only for delinquent support. The request is for the sole purpose of modifying the amount of delinquent support that has accrued under a support order.

99.91(3) Temporary order. The request is for the modification of a temporary support order.

99.91(4) Two-year time frame. The request is for a cost-of-living alteration and it has been less than two years since the order was filed with the court or last reviewed, modified, or altered.

99.91(5) Change of circumstances. The request is based on a substantial change in circumstances and:

a. The requestor’s net income has not changed by at least 50 percent, as required in paragraph 99.83(1)“a,” or

b. The requestor has not provided adequate documentation of the change in income, as required in subrule 99.85(1), or

c. The change in income has not yet lasted for three months, as required in paragraph 99.83(1)“b,” or

d. The change in income is not expected to last another three months, as required in paragraph 99.83(1)“b,” or

e. The change in income is due to material misrepresentation of fact, as explained in rule 441—99.87(252H).

[ARC 3719C, IAB 3/28/18, effective 7/1/18]

441—99.92(252H) Withdrawing requests. If the requesting party contacts the child support recovery unit to withdraw the request, the child support recovery unit shall notify the nonrequesting party of the requesting party’s desire to withdraw the modification request. If the nonrequesting party indicates, in writing, a desire to continue with the modification process, the child support recovery unit shall proceed, and if appropriate, modify the support order. If there is no response from the nonrequesting party or if the nonrequesting party also wants the process to end, the unit shall end the modification process. If the
unit initiated the modification action, the unit may terminate the process if, after notifying both parents, neither parent indicates a desire to continue with the modification.

These rules are intended to implement Iowa Code chapter 252H.

441—99.93 to 99.100 Reserved.

DIVISION VI
SUSPENSION AND REINSTATEMENT OF SUPPORT
PART A
SUSPENSION BY MUTUAL CONSENT

441—99.101(252B) Definitions. As used in this part, unless the context otherwise requires:

“Caretaker” means a natural person with whom a child is residing and who is not legally entitled to receive support for that child pursuant to the order that is the subject of the pending suspension request.

“Child” means the same as defined in Iowa Code section 252E.1.

“Child support recovery unit” or “unit” means the same as defined in rule 441—95.1(252B) and Iowa Code section 252B.1.

“Obligee” means a custodial parent or other natural person legally entitled to receive a support payment on behalf of a child.

“Obligor” means a noncustodial parent or other natural person who is ordered to pay support pursuant to the order that is the subject of the pending suspension request.

“Public assistance” means the same as defined in Iowa Code section 252H.2.

“Spousal support” means either a set amount of monetary support, or medical support as defined in Iowa Code section 252E.1, for the benefit of a spouse or former spouse, including alimony, maintenance, or any other term used to describe these obligations.

“Step change” means a change designated in a support order that specifies the amount of the child support obligation as the number of children entitled to support under the order changes.

“Support” means the same as defined in Iowa Code section 252D.16, and shall include spousal support and support for a child.

“Support for a child” means either a set amount of monetary support (child support), or medical support as defined in Iowa Code section 252E.1, for the benefit of a child. This term does not include spousal support as defined in this rule.

“Support order” means the same as a “court order” as defined in Iowa Code section 252C.1.

[ARC 2813C, IAB 11/9/16, effective 1/1/17]

441—99.102(252B) Availability of service. The child support recovery unit shall provide the services described in this part only with respect to support orders entered or registered in this state for which the unit is providing enforcement services in accordance with Iowa Code chapter 252B to collect current or accrued support.

99.102(1) Services described in this part shall only be provided if a court in this state would have continuing, exclusive jurisdiction to suspend and reinstate the order under Iowa Code chapter 252K.

99.102(2) Services described in this part shall be provided only if no prior request for suspension of all or part of a support order has been filed with the unit pursuant to Iowa Code section 252B.20 and no prior request for suspension of all or part of a support order has been served by the unit pursuant to Iowa Code section 252B.20A during the two-year period preceding the request.

[ARC 2813C, IAB 11/9/16, effective 1/1/17]

441—99.103(252B) Basis for suspension of support.

99.103(1) Reconciliation. The child support recovery unit shall assist an obligor and obligee in suspending support for a child and, if contained in a child support order, spousal support, when the obligor and obligee are reconciled and are residing together, with at least one child entitled to support under the order, in the same household.

99.103(2) Change in residency. The unit shall assist an obligor and obligee in suspending support for a child when the child is residing with the obligor; however, the unit shall not assist in suspending
any spousal support provisions of a support order on this basis. The unit shall also assist an obligor and obligee in suspending support for a child residing with a caretaker who has not requested unit services, if the child is not receiving public assistance.

99.103(3) Affected children. The unit shall assist an obligor and obligee in suspending all or part of a support order as provided in this section if the basis for suspension as described in this rule applies to the children entitled to support under the order to be suspended as follows:

a. If the basis for suspension applies to all of the children, the unit shall assist in suspending support obligations for all of the children.

b. If the basis for suspension applies to at least one but not all of the children and if the support order includes a step change, the unit shall assist in suspending the support obligations for children for whom the basis for suspension applies.

99.103(4) Limited to current support. The provisions in this section for suspending support apply only toward ongoing or current support. Any support that has accrued prior to the entry of an order suspending support, including judgments for past periods of time, is unaffected by the suspension.

99.103(5) Duration of conditions. The basis for suspension of support as provided in subrule 99.103(2) and subrule 99.103(3) must reasonably be expected to continue for not less than six months from the date a request for assistance to suspend is received by the child support recovery unit.

[ARC 2813C, IAB 11/9/16, effective 1/1/17]

441—99.104(252B) Request for assistance to suspend.

99.104(1) Submitting a request. The obligor and obligee subject to a support order being enforced by the unit may request that the unit assist in having the ongoing support provisions suspended as follows:

a. A request for suspension shall be submitted to the local child support unit providing services using Form 470-3033, Request to Suspend Support, and Form 470-3032, Affidavit Regarding Suspension of Support.

b. The unit shall provide Forms 470-3032 and 470-3033 to the obligor or obligee upon request.

c. Both forms must be signed by both the obligor and the obligee affected by the order to be suspended. In the event that current support payments are assigned to an individual or entity other than the obligee named in the original order, but may revert to the original obligee at a future date without court action, both the original obligee and the current assignee must sign both forms.

d. Form 470-3032 must be notarized.

e. The request shall contain sufficient information to allow the local unit to identify the court order and parties involved, and a statement that the obligor and obligee expect the basis for suspension to continue for not less than six months.

f. If the obligor and obligee are requesting suspension of more than one order at the same time, the obligor and obligee shall be required to submit only one copy of Form 470-3033, identifying each order the request involves; however, the obligor and obligee shall be required to submit a separate, signed and notarized affidavit, Form 470-3032, for each order.

99.104(2) Denying a request. The local unit providing services shall issue a written notice to the obligor and obligee indicating that a properly completed request is denied.

a. This notice shall be sent by first-class regular mail to the last-known address of the obligor and obligee or, if applicable, to the last-known address of the obligor’s or obligee’s attorney.

b. If the basis for suspension is reconciliation, one notice shall be sent to the address shared by the obligor and obligee. If the basis for suspension is a change in residency of the children entitled to support, a separate notice shall be issued to the obligor and obligee at their respective last-known addresses.

c. The notice denying a request shall indicate the reason for denial.

d. A request for suspension shall be denied when the conditions specified in Iowa Code section 252B.20, rule 441—99.102(252B), or rule 441—99.103(252B) are not met.

e. Denial of a request is not subject to appeal or review under Iowa Code chapter 17A.

[ARC 2813C, IAB 11/9/16, effective 1/1/17]
441—99.105(252B) Order suspending support. To approve a request to suspend support, the unit shall prepare and present to the district court an order suspending support as provided in Iowa Code section 252B.20.

99.105(1) When the basis for suspension is reconciliation, the suspension shall apply to any ongoing support provisions of the order, including medical support, with respect to any child residing with the parents and with respect to any spouse or former spouse entitled to support under the order to be suspended.

99.105(2) When the basis for suspension is a change in residency of one or more of the children entitled to support, the suspension shall apply to ongoing support provisions, including medical support, with respect to only the children entitled to support under the order who are residing with the obligor. Any spousal support also ordered in the same support order shall remain unaffected by this action.

99.105(3) A copy of the filed order shall be sent by first-class regular mail to the last known address of the obligor and obligee, or, if applicable, to the last known address of the obligor’s or obligee’s attorney.

[ARC 2813C, IAB 11/9/16, effective 1/1/17]

441—99.106(252B) Suspension of enforcement of current support. The child support recovery unit shall suspend enforcement actions intended to collect or enforce any current support obligation that would have accrued during the time the support obligation is suspended. The unit shall continue to provide all appropriate enforcement services to collect any support not suspended and any arrearages that accrued before the effective date of the suspension.

PART B
SUSPENSION BY PAYOR’S REQUEST

441—99.107(252B) Definitions. As used in this part, unless the context otherwise requires:

“Caretaker” means a natural person with whom a child is residing and who is not legally entitled to receive support for that child pursuant to the order that is the subject of the pending suspension request.

“Child” means the same as defined in Iowa Code section 252E.1.

“Child support recovery unit” or “unit” means the same as defined in rule 441—95.1(252B) and Iowa Code section 252B.1.

“Obligee” means a custodial parent or other natural person legally entitled to receive a support payment on behalf of a child.

“Obligor” means a noncustodial parent or other natural person who is ordered to pay support pursuant to the order that is the subject of the pending suspension request.

“Public assistance” means the same as defined in Iowa Code section 252H.2.

“Step change” means a change designated in a support order that specifies the amount of the child support obligation as the number of children entitled to support under the order changes.

“Support” means the same as defined in Iowa Code section 252D.16 and shall include support for a child.

“Support for a child” means either a set amount of monetary support (child support), or medical support as defined in Iowa Code section 252E.1, for the benefit of a child. This term does not include spousal support as defined in rule 441—99.101(252B).

“Support order” means the same as a “court order” as defined in Iowa Code section 252C.1.

[ARC 2813C, IAB 11/9/16, effective 1/1/17]

441—99.108(252B) Availability of service. The child support recovery unit shall provide the services described in this part only with respect to support orders entered pursuant to Iowa Code chapter 252A, 252C or 252F for which the unit is providing enforcement services in accordance with Iowa Code chapter 252B to collect current or accrued support.

99.108(1) Services described in this part shall only be provided if a court in this state would have continuing, exclusive jurisdiction to suspend and reinstate the order pursuant to Iowa Code chapter 252K.
99.108(2) Services described in this part shall be provided only if no prior request for suspension of all or part of a support order has been filed with the unit pursuant to Iowa Code section 252B.20 and no prior request for suspension of all or part of a support order has been served by the unit pursuant to Iowa Code section 252B.20A during the two-year period preceding the request.

[ARC 2813C, IAB 11/9/16, effective 1/1/17]

441—99.109(252B) Basis for suspension of support.

99.109(1) Child residing with obligor or caretaker. The unit shall assist an obligor in suspending support for a child residing with the obligor or with a caretaker who has not requested unit services, if the child has been residing with the obligor or caretaker for more than 60 consecutive days.

99.109(2) Orders eligible for suspension.

a. The unit shall assist an obligor in suspending support for a child under this part only when there is no order in effect regarding legal custody, physical care, visitation or other parenting time for the child.

b. If an order exists that contains language regarding legal custody, physical care, visitation or other parenting time for the child, the unit shall deny the suspension request.

99.109(3) Children on public assistance. The children for whom ongoing support is being suspended shall not be receiving public assistance pursuant to Iowa Code chapter 239B or 249A or a comparable law of another state or foreign country, or if the children are receiving public assistance, the obligor must be considered to be a member of the same household as the children for the purposes of public assistance eligibility.

99.109(4) Duration of conditions. The basis for suspension of support under this part must reasonably be expected to continue for not less than six months from the date a request for assistance to suspend is received by the child support recovery unit.

99.109(5) Affected children. The unit shall assist an obligor in suspending all or part of a support order as provided in this part if the basis for suspension as described in this rule applies to the children entitled to support under the order to be suspended as follows:

a. If the basis for suspension applies to all of the children, the unit shall assist in suspending support obligations for all of the children.

b. If the basis for suspension applies to at least one but not all of the children and if the support order includes a step change, the unit shall assist in suspending the support obligations for children for whom the basis for suspension applies.

99.109(6) Limited to current support. The provisions in this part for suspending support apply only toward ongoing or current support. Any support that has accrued prior to the entry of an order suspending support, including judgments for past periods of time, is unaffected by the suspension.

[ARC 2813C, IAB 11/9/16, effective 1/1/17]

441—99.110(252B) Request for assistance to suspend. The obligor subject to a support order being enforced by the unit may request that the unit assist in having the ongoing support provisions suspended as follows:

99.110(1) Submitting a request.

a. A request for suspension shall be submitted to the local child support unit providing services using Form 470-5348, Request from the Payor to Suspend Support.

b. The unit shall provide Form 470-5348 to the obligor upon request.

c. The request form must be signed by the obligor affected by the order to be suspended.

d. The request shall contain sufficient information to allow the local unit to identify the court order and parties involved and shall attest that the children have lived in the obligor’s household or the caretaker’s household for more than 60 consecutive days and are expected to live there for at least six months.

99.110(2) Submitting an affidavit. After receiving a valid request for suspension, the local unit shall provide the requestor with Form 470-5349, Affidavit Requesting Suspension of Support Based on Payor’s Request.
The obligor shall submit the affidavit for suspension to the local child support unit providing services. If the request for suspension is made pursuant to Iowa Code section 252B.20A(17), the caretaker must also submit an affidavit, Form 470-5349.

b. Form 470-5349 must be signed, attesting to the existence of the conditions under subrules 99.109(1) through 99.109(4). Form 470-5349 must be notarized.

c. If the obligor is requesting suspension of more than one order at the same time, the obligor shall be required to submit only one copy of Form 470-5348, identifying each order the request involves; however, the obligor shall be required to submit a separate, signed and notarized affidavit, Form 470-5349, for each order. [ARC 2813C, IAB 11/9/16, effective 1/1/17]

441—99.111(252B) Determining eligibility for suspension. Upon receipt of the request for suspension and the properly executed and notarized affidavit, the unit shall review the request and the affidavit to determine that the criteria have been met.

99.111(1) If the criteria are not met. If the criteria have not been met, the local unit providing services shall issue a written notice to the obligor indicating that the request is denied.

a. The notice shall be sent by first-class regular mail to the last-known address of the obligor or, if applicable, to the last-known address of the obligor’s attorney.

b. The notice shall indicate the reason for denial and notify the obligor of the right to proceed through private counsel. Denial of the request is not subject to contested case proceedings or further review pursuant to Iowa Code chapter 17A.

99.111(2) If the criteria are met. If the criteria are met, the unit shall proceed as follows:

a. The unit shall serve Form 470-5351, Notice of Intent to Payee to Suspend a Child Support Obligation Based on Payor’s Request, and Form 470-5352, Payee’s Affidavit Objecting to Suspension of Support, and supporting documents on the obligee by any means provided in Iowa Code section 252B.26. The notice to the obligee shall include all of the following:

   (1) Information sufficient to identify the parties and the support order affected.

   (2) An explanation of the procedure for suspension under Part B and reinstatement of support under Part C of this division.

   (3) An explanation of the rights and responsibilities of the obligee to respond to the action.

   (4) A statement that, within 20 days of service, the obligee must submit a signed and notarized response to the unit objecting to at least one of the assertions in subrules 99.109(1) through 99.109(4). The statement shall inform the obligee that if, within 20 days of service, the obligee fails to submit a response as specified in this subparagraph, notwithstanding Rules of Civil Procedure 1.972(2) and 1.972(3), the unit will prepare and submit an order.

b. No sooner than 30 days after service on the obligee, the unit shall do one of the following:

   (1) If the obligee submits a signed and notarized objection to at least one of the assertions in subrules 99.109(1) through 99.109(4), deny the request and notify the parties in writing that the request is denied, providing reasons for the denial, and notifying the parties of the right to proceed through private counsel. Denial of the request is not subject to contested case proceedings or further review pursuant to Iowa Code chapter 17A.

   (2) If the obligee cannot be served, the local unit providing services shall issue a written notice to the obligor indicating the request is denied, following the procedure described in subrule 99.111(2).

   (3) If the obligee does not timely submit a signed and notarized objection to the unit, prepare an order following the procedure described in rule 441—99.112(252B).

[ARC 2813C, IAB 11/9/16, effective 1/1/17]

441—99.112(252B) Order suspending support. After approving a request to suspend support and properly serving the obligee, the unit shall prepare and present to the district court an order suspending support as provided in Iowa Code section 252B.20A.

99.112(1) The suspension shall apply to ongoing support provisions, including medical support, with respect to only the children entitled to support under the order who are residing with the obligor or caretaker.
99.112(2) A copy of the filed order shall be sent by first-class regular mail to the last-known address of the obligor and obligee or, if applicable, to the last-known address of the obligor’s or obligee’s attorney. [ARC 2813C, IAB 11/9/16, effective 1/1/17]

441—99.113(252B) Suspension of enforcement of current support. The child support recovery unit shall suspend enforcement actions intended to collect or enforce any current support obligation that would have accrued during the time the support obligation is suspended. The unit shall continue to provide all appropriate enforcement services to collect any support not suspended and any arrearages that accrued before the effective date of the suspension. [ARC 2813C, IAB 11/9/16, effective 1/1/17]

PART C
REINSTATEMENT OF SUPPORT

441—99.114(252B) Request for reinstatement. The unit may request that the court reinstate the suspended support obligation in accordance with the procedures found in Iowa Code sections 252B.20 and 252B.20A.

99.114(1) Either the obligor or the obligee affected by the suspended order may request reinstatement by submitting a written request for reinstatement to the child support recovery unit. The request must indicate that reinstatement is being requested and the reason for reinstatement and must contain sufficient information to identify the court order and parties involved. The request must also be signed by the requesting party.

99.114(2) The unit may, at its own initiative, request that the court reinstate a support obligation when it is determined that a child for whom the obligation was suspended is receiving public assistance benefits.

99.114(3) The unit shall issue a written notice approving or denying the request to any obligor or obligee requesting reinstatement. This notice shall be sent by first-class regular mail to the last-known address of the requesting party and shall indicate any reason for denial.

99.114(4) A properly completed request for reinstatement shall be denied when any of the following conditions exist:
   a. The request is made by someone other than the obligor, the obligee, or the obligor’s or obligee’s attorney.
   b. The unit is no longer providing enforcement services for the suspended order.
   c. The request is received more than six months after the date of the filing of the order suspending support.
   d. The request is for partial reinstatement of the suspended support order for some but not all of the children, and the order does not contain a step change.
   e. A court in this state would not have continuing, exclusive jurisdiction to reinstate the order under Iowa Code chapter 252K. [ARC 2813C, IAB 11/9/16, effective 1/1/17]

441—99.115(252B) Reinstatement. The child support recovery unit shall follow the procedures in Iowa Code sections 252B.20 and 252B.20A in seeking to have the court reinstate a support order.

99.115(1) The unit shall request that the court reinstate a spousal support provision previously suspended if the provision was included in the suspension in accordance with subrule 99.105(1) and if the unit receives a properly completed request from the obligor or the obligee.

99.115(2) The unit shall seek to have the previously suspended support for a child reinstated under this part when the conditions in paragraph “a” or “b” of this subrule are met. This provision shall not prohibit any party, including the child support recovery unit, from taking other action to establish support as provided for by law.
   a. The basis for suspension no longer applies to any of the children for whom support was suspended; or
b. The basis for suspension continues to apply to some but not all of the children for whom support was suspended, and there is a step change in the order.

[ARC 2813C, IAB 11/9/16, effective 1/1/17]

441—99.116(252B) Reinstatement of enforcement of support. If a suspended support obligation is reinstated, the unit shall also reinstate all appropriate enforcement measures to enforce all reinstated ongoing support provisions of the support order.

[ARC 2813C, IAB 11/9/16, effective 1/1/17]

441—99.117(252B) Temporary suspension becomes final. The temporary suspension of a support order under this division shall become final if not reinstated in accordance with Iowa Code sections 252B.20 and 252B.20A.

[ARC 2813C, IAB 11/9/16, effective 1/1/17]

The rules in this division are intended to implement Iowa Code sections 252B.20 and 252B.20A.

[Filed 8/12/93, Notice 6/23/93—published 9/1/93, effective 11/1/93]
[Filed 7/12/95, Notice 5/24/95—published 8/2/95, effective 10/1/95]
[Filed 2/14/96, Notice 12/20/95—published 3/13/96, effective 5/1/96]
[Filed 7/10/96, Notice 6/5/96—published 7/31/96, effective 10/1/96]
[Filed 10/9/96, Notice 8/28/96—published 11/6/96, effective 11/1/97]
[Filed 10/15/97, Notice 8/13/97—published 11/5/97, effective 1/1/98]
[Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]
[Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 6/1/98]
[Filed 4/15/99, Notice 2/10/99—published 5/5/99, effective 7/1/99]
[Filed 7/13/00, Notice 5/17/00—published 8/9/00, effective 10/1/00]
[Filed 1/9/03, Notice 11/13/02—published 2/5/03, effective 4/1/03]
[Filed 11/16/05, Notice 9/14/05—published 12/7/05, effective 2/1/06]
[Filed emergency 1/19/07—published 2/14/07, effective 1/20/07]
[Filed ARC 9352B (Notice ARC 9195B, IAB 11/3/10), IAB 2/9/11, effective 4/1/11]
[Filed ARC 1357C (Notice ARC 1228C, IAB 12/11/13), IAB 3/5/14, effective 5/1/14]
[Filed ARC 2813C (Notice ARC 2702C, IAB 8/31/16), IAB 11/9/16, effective 1/1/17]
[Filed ARC 3719C (Notice ARC 3595C, IAB 1/31/18), IAB 3/28/18, effective 7/1/18]
[Filed ARC 4576C (Notice ARC 4441C, IAB 5/22/19), IAB 7/31/19, effective 9/4/19]
CHAPTER 63
RESIDENTIAL CARE FACILITY—THREE- TO FIVE-BED SPECIALIZED LICENSE
[Prior to 7/15/87, Health Department[470] Ch 63]

481—63.1(135C) Definitions. For the purpose of these rules, the following terms shall have the meanings indicated in this chapter. The definitions set out in Iowa Code section 135C.1 shall be considered to be incorporated verbatim in the rules.

“Accommodation” means the provision of lodging, including sleeping, dining, and living areas.

“Administrator” means a person approved by the department who administers, manages, supervises, and is in general administrative charge of a three- to five-bed residential care facility, whether or not such individual has an ownership interest in such facility, and whether or not the functions and duties are shared with one or more individuals.

“Ambulatory” means the condition of a person who immediately and without aid of another person is physically and mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

“Basement” means that part of a building where the finish floor is more than 30 inches below the finish grade of the building.

“Board” means the regular provision of meals.

“Change of ownership” means the purchase, transfer, assignment or lease of a licensed three- to five-bed residential care facility.

“Communicable disease” means a disease caused by the presence within a person’s body of a virus or microbial agents which may be transmitted either directly or indirectly to other persons.

“Department” means the state department of inspections and appeals.

“Interdisciplinary team” means the group of persons who develop a single, integrated, individual program plan to meet a resident’s needs for services. The interdisciplinary team consists of, at a minimum, the resident, the resident’s legal guardian if applicable, the resident’s advocate if desired by the resident, a referral agency representative, other appropriate staff members, other providers of services, and other persons relevant to the resident’s needs.

“Legal representative” means the resident’s guardian or conservator if one has been appointed or the resident’s power of attorney.

“Mechanical restraint” means restriction by the use of a mechanical device of a resident’s mobility or ability to use the hands, arms or legs.

“Medication” means any drug, including over-the-counter substances.

“Nonambulatory” means the condition of a person who immediately and without the aid of another person is not physically or mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

“Personal care” means assistance with the activities of daily living which the recipient can perform only with difficulty. Examples are help in getting in and out of bed, assistance with personal hygiene and bathing, help with dressing and eating, and supervision over medications which can be self-administered.

“Physical restraint” means direct physical contact on the part of a staff person to control a resident’s physical activity for the resident’s own protection or for the protection of others.

“Primary care provider” means any of the following who provide primary care and meet licensure standards:
1. A physician who is a family or general practitioner or an internist.
2. An advanced registered nurse practitioner.
3. A physician assistant.

“Program of care” means all services being provided for a resident in a health care facility.

“Prone restraint” means a restraint in which a resident is in a face-down position against the floor or another surface.

“Rate” means that daily fee charged for all residents equally and shall include the cost of all minimum services required in these rules.

“Records” includes electronic records.
“Responsible party” means the person who signs or cosigns the residency agreement required by rule 481—63.12(135C) or the resident’s legal representative. In the event that a resident has neither a legal representative nor a person who signed or cosigned the resident’s residency agreement, the term “responsible party” shall include the resident’s sponsoring agency, e.g., the department of human services, the U.S. Department of Veterans Affairs, a religious group, fraternal organization, or foundation that assumes responsibility and advocates for its client patients and pays for their health care.

“Restraints” means the measures taken to control a resident’s physical activity for the resident’s own protection or for the protection of others.

“Specialized residential care facility license” means a license for three- to five-bed residential care facilities serving persons with an intellectual disability, chronic mental illness, a developmental disability or brain injury.

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.2(135C,17A) Waiver or variance. A waiver or variance from these rules may be granted by the director of the department in accordance with 481—Chapter 6. A request for waiver or variance will be granted or denied by the director within 120 calendar days of receipt.

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.3(135C) Application for licensure.

63.3(1) Application and licensing—new facility or change of ownership. In order to obtain a specialized residential care facility license for a facility not currently licensed as a specialized residential care facility or for a specialized residential care facility when a change of ownership is contemplated, the applicant must:

a. Make application at least 30 days prior to the proposed opening date of the facility. Application shall be made on forms provided by the department.

b. Meet all of the rules, regulations, and standards contained in this chapter and in 481—Chapter 50.

c. Submit a letter of intent and a written résumé of care. The résumé of care shall meet the requirements of subrule 63.3(2).

d. Submit a floor plan of each floor of the residential care facility. The floor plan of each floor shall be drawn on 8½” × 11” paper, show room areas in proportion, room dimensions, window and door locations, designation of the use of each room, and the room numbers for all rooms, including bathrooms.

e. Submit a photograph of the front and side of the residential care facility.

f. Submit the fee for a specialized residential care facility license in accordance with 481—paragraph 50.3(2)“a.”

g. Comply with all other local statutes and ordinances in existence at the time of licensure.

h. Submit a certificate signed by the state or local fire inspection authority as to compliance with fire safety rules and regulations.

63.3(2) Résumé of care. The résumé of care shall describe the following:

a. Purpose of the facility;

b. Criteria for admission to the facility;

c. Ownership of the facility;

d. Composition and responsibilities of the governing board;

e. Qualifications and responsibilities of the administrator;

f. Medical services provided to residents, to include the availability of emergency medical services in the area and the designation of a primary care provider to be responsible for residents in an emergency;

g. Dental services provided to residents and available in the area;

h. Nursing services provided to residents, if applicable;

i. Personal services provided to residents, including supervision of or assistance with activities of daily living;

j. Activity program;
k. Dietary services, including qualifications of the person in charge, consultation service (if applicable) and meal service;  
l. Other services available as applicable, including social services, physical therapy, occupational therapy, and recreational therapy;  
m. Housekeeping;  
n. Laundry;  
o. Physical plant; and  
p. Staffing provided to meet residents’ needs.  
63.3(3) Renewal application. In order to obtain a renewal of the specialized residential care facility license, the applicant must submit the following:  
a. The completed application form 30 days prior to the annual license renewal date of the residential care facility license;  
b. The fee for a specialized residential care facility license in accordance with 481—paragraph 50.3(2) “a”;
  c. An approved current certificate signed by the state or local fire inspection authority as to compliance with fire safety rules and regulations;  
d. Changes to the résumé of care, if any; and  
e. Changes to the current residency agreement, if any.

[ARC 3740C, IAB 4/11/18, effective 5/16/18; ARC 4577C, IAB 7/31/19, effective 9/4/19]

481—63.4(135C) Issuance of license. Licenses are issued to the person, entity or governmental unit with responsibility for the operation of the facility and for compliance with all applicable statutes, rules and regulations.  

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.5(135C) General requirements.  
63.5(1) The license shall be displayed in the facility in a conspicuous place which is accessible to the public. (III)  
63.5(2) The license shall be valid only in the possession of the licensee to whom it is issued.  
63.5(3) The posted license shall accurately reflect the current status of the facility. (III)  
63.5(4) The license shall expire one year after the date of issuance or as indicated on the license.  
63.5(5) The licensee shall:  
a. Assume the responsibility for the overall operation of the facility. (I, II, III)  
b. Be responsible for compliance with all applicable laws and with the rules of the department. (I, II, III)  
c. Provide an organized continuous 24-hour program of care commensurate with the needs of the residents. (I, II, III)  
63.5(6) Each citation or a copy of each citation issued by the department for a class I or class II violation shall be prominently posted by the facility in plain view of the residents, visitors, and persons inquiring about placement in the facility. The citation or copy of the citation shall remain posted until the violation is corrected to the satisfaction of the department. (I, II, III)  

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.6(135C) Required notifications to the department. The department shall be notified:  
63.6(1) Thirty days before any proposed change in the residential care facility’s functional operation or addition or deletion of required services; (III)  
63.6(2) Thirty days before the beginning of the renovation, addition, functional alteration, change of space utilization, or conversion in the residential care facility or on the premises; (III)  
63.6(3) Thirty days before closure of the residential care facility; (III)  
63.6(4) Within two weeks of any change in administrator; (III)  
63.6(5) Ninety days before a change in the category of license; (III)  
63.6(6) Thirty days before a change of ownership. The licensee shall:  
a. Inform the department of the pending change of ownership; (III)
b. Inform the department of the name and address of the prospective purchaser, transferee, assignee, or lessee; (III)

c. Submit a written authorization to the department permitting the department to release all information of whatever kind from the department’s files concerning the licensee’s residential care facility to the named prospective purchaser, transferee, assignee, or lessee. (III)

[ARC 3740C; IAB 4/11/18, effective 5/16/18]

481—63.7(135C) Administrator. Each facility shall have one person in charge, duly approved by the department or acting in a provisional capacity in accordance with these rules. (III)

63.7(1) Qualifications of an administrator:

a. The administrator shall be at least 21 years of age and shall have a high school diploma or equivalent. (III) In addition, this person shall meet at least one of the following conditions:

1. Have a two-year degree in human services, psychology, sociology, nursing, health care administration, public administration, or a related field and have a minimum of two years’ experience in the field; or (III)

2. Have a four-year degree in human services, psychology, sociology, nursing, health care administration, public administration, or a related field and have a minimum of one year of experience in the field; or (III)

3. Have a master’s degree in human services, psychology, sociology, nursing, health care administration, public administration, or a related field and have a minimum of one year of experience in the field; or (III)

4. Be a licensed nursing home administrator; or (III)

5. Have completed a one-year educational training program approved by the department for residential care facility administrators; or (III)

6. Have passed the National Association of Long Term Care Administrator Boards (NAB) RC/AL administrator licensure examination; or

7. Have two years of direct care experience and at least six months of administrative experience in a residential care facility. (III)

b. The administrator shall have at least one year of documented experience in a supervisory or direct care position working with persons with an intellectual disability, mental illness, a developmental disability, or brain injury.

c. An individual employed as an administrator on May 16, 2018, will be deemed to meet the requirements of this subrule.

63.7(2) Duties of an administrator. The administrator shall:

a. Select and direct competent personnel who provide services for the residential care program. (III)

b. Provide in-service educational programming for all employees with direct resident contact and maintain records of programs and participants. (III) In-service educational programming offered during each calendar year shall include, at minimum, the following topics: (I, II, III)

1. Infection control.

2. Emergency preparedness (e.g., fire, tornado, flood, 911).

3. Meal time procedures/dietary.

4. Resident activities.

5. Mental illness, brain injury or intellectual disabilities, including behavioral intervention, de-escalation, and crisis intervention techniques.

6. Resident safety/supervision.

7. Resident rights.

8. Medication education, to include administration, storage and drug interactions.

9. Resident service plans/programming/goals.

63.7(3) Administrator serving at more than one residential care facility. The administrator may be responsible for no more than 150 beds in total if the administrator is an administrator of more than one facility. (II)
a. An administrator of more than one facility shall designate in writing an administrative staff person in each facility who shall be responsible for directing programs in the facility.

b. The administrative staff person designated by the administrator shall:

1. Have at least one year of documented experience in a supervisory or direct care position working with persons with an intellectual disability, mental illness, a developmental disability, or brain injury; (II, III)

2. Be knowledgeable of the operation of the facility; (II, III)

3. Have access to records concerned with the operation of the facility; (II, III)

4. Be capable of carrying out administrative duties and of assuming administrative responsibilities; (II, III)

5. Be at least 21 years of age; (III)

6. Be empowered to act on behalf of the licensee concerning the health, safety and welfare of the residents; and (II, III)

7. Have training in emergency response, including how to respond to residents’ sudden illnesses. (II, III)

c. If an administrator serves more than one facility, the administrator must designate in writing regular and specific times during which the administrator will be available to consult with staff and residents to provide direction and supervision of resident care and services. (II, III)

63.7(4) Provisional administrator. A provisional administrator may be appointed on a temporary basis by the residential care facility licensee to assume the administrative responsibilities for a residential care facility for a period not to exceed one year when the facility has lost its administrator and has not been able to replace the administrator, provided that the department has been notified and has approved the provisional administrator prior to the date of the provisional administrator’s appointment. (III) The provisional administrator must meet the requirements of paragraph 63.7(3) “b.”

63.7(5) Temporary absence of administrator:

a. In the temporary absence of the administrator, a responsible person shall be designated in writing to the department to be in charge of the facility. (III) The person designated shall:

1. Be knowledgeable of the operation of the facility; (III)

2. Have access to records concerned with the operation of the facility; (III)

3. Be capable of carrying out administrative duties and of assuming administrative responsibilities; (III)

4. Be at least 21 years of age; (III)

5. Be empowered to act on behalf of the licensee during the administrator’s absence concerning the health, safety, and welfare of the residents; (III)

6. Have training in emergency response, including how to respond to residents’ sudden illnesses. (II, III)

b. If the administrator is absent for more than six weeks, a provisional administrator must be appointed pursuant to subrule 63.7(4).

[ARC 3740C; IAB 4/11/18, effective 5/16/18]

481—63.8(135C) Personnel.

63.8(1) Alcohol and drug use prohibited. No person under the influence of intoxicating drugs or alcoholic beverages shall be permitted to provide services in a residential care facility. (I, II)

63.8(2) Job description. There shall be a written job description developed for each category of worker. The job description shall include the job title, responsibilities and qualifications. (III)

63.8(3) Employee criminal record, child abuse and dependent adult abuse checks and employment of individuals who have committed a crime or have a founded abuse. The facility shall comply with the requirements found in Iowa Code section 135C.33 and rule 481—50.9(135C) related to completion of criminal record checks, child abuse checks, and dependent adult abuse checks and to employment of individuals who have committed a crime or have a founded abuse. (I, II, III)

63.8(4) Personnel record. A personnel record shall be kept for each employee and shall include but not be limited to the following information about the employee: name and address; social security
number; date of birth; date of employment; position; job description; experience and education; results of criminal record checks, child abuse checks and dependent adult abuse checks; and date of discharge or resignation. (III)

63.8(5) Supervision and staffing.  
   a. The facility shall provide sufficient staff to meet the needs of the residents served. (I, II, III)  
   b. Personnel in a specialized residential care facility shall provide 24-hour coverage for residential care services. Personnel shall be available and responsive to residents’ needs at all times while on duty. (I, II, III)  
   c. Direct care staff shall be present in the facility unless all residents are involved in activities away from the facility. (I, II, III)  
   d. Staff shall be aware of and provide supervision levels based on the present needs of the residents in the staff’s care. The facility shall document the supervision of residents who require more than general supervision, as defined by facility policy. (I, II, III)  
   e. The facility shall maintain an accurate record of actual hours worked by employees. (III)  

63.8(6) Physical examination and screening. Employees shall have a physical examination within 12 months prior to beginning employment and every four years thereafter. Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59. (I, II, III)  

[ARC 3740C, IAB 4/11/18, effective 5/16/18; ARC 4577C, IAB 7/31/19, effective 9/4/19]

481—63.9(135C) General policies. The licensee shall establish and implement written policies and procedures as set forth in this rule. The policies and procedures shall be available for review by the department, other agencies designated by Iowa Code section 135C.16(3), staff, residents, residents’ families or legal representatives, and the public and shall be reviewed by the licensee annually. (II)

63.9(1) Facility operation. The licensee shall establish written policies for the operation of the facility, including but not limited to the following: (III)

   a. Personnel; (III)  
   b. Admission; (III)  
   c. Evaluation services; (II, III)  
   d. Programming and individual program plans; (II, III)  
   e. Registered sex offender management; (II, III)  
   f. Crisis intervention; (II, III)  
   g. Discharge or transfer; (III)  
   h. Medication management, including self-administration of medications and chemical restraints; (III)

   i. Resident property; (II, III)  
   j. Resident finances; (II, III)  
   k. Records; (III)  
   l. Health and safety; (II, III)  
   m. Nutrition; (III)  
   n. Physical facilities and maintenance; (III)  
   o. Resident rights; (II, III)  
   p. Investigation and reporting of alleged dependent adult abuse; (II, III)  
   q. Investigation and reporting of accidents or incidents; (II, III)  
   r. Transportation of residents; (II, III)  
   s. Resident supervision; (II, III)  
   t. Smoking; (III)  
   u. Visitors; (III)  
   v. Disaster/emergency planning; (III) and  
   w. Infection control. (III)

63.9(2) Personnel policies. Written personnel policies shall include the hours of work and attendance at educational programs. (III)
63.9(3) *Infection control*. The facility shall have a written and implemented infection control program, which shall include policies and procedures based on guidelines issued by the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. The infection control program shall address the following:

a. Techniques for hand washing; (I, II, III)
b. Techniques for the handling of blood, body fluids, and body wastes; (I, II, III)
c. Dressings, soaks or packs; (I, II, III)
d. Infection identification; (I, II, III)
e. Resident care procedures to be used when there is an infection present; (I, II, III)
f. Sanitation techniques for resident care equipment; (I, II, III)
g. Techniques for sanitary use and reuse of feeding syringes and single-resident use and reuse of urine collection bags; (I, II, III) and

h. Techniques for use and disposal of needles, syringes, and other sharp instruments. (I, II, III)

63.9(4) *Resident care techniques*. The facility shall have written and implemented procedures to be followed if a resident needs any of the following treatment or devices:

a. Intravenous or central line catheter; (I, II, III)
b. Urinary catheter; (I, II, III)
c. Respiratory suction, oxygen or humidification; (I, II, III)
d. Decubitus care; (I, II, III)
e. Tracheostomy; (I, II, III)
f. Nasogastric or gastrostomy tubes; (I, II, III)
g. Sanitary use and reuse of feeding syringes and single-resident use and reuse of urine collection bags. (I, II, III)

63.9(5) *Emergency care*. The facility shall establish written policies for the provision of emergency medical care to residents and employees in case of sudden illness or accident. The policies shall include a list of those individuals to be contacted in case of an emergency. (I, II, III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.10(135C) *Admission, transfer and discharge.*

63.10(1) *General admission policies.*

a. Residents shall be admitted to a specialized residential care facility only on a written order signed by a primary care provider or psychiatrist, specifying the level of care, and certifying that the individual being admitted requires no more than personal care and supervision and does not require routine nursing care. (II, III)

b. No residential care facility shall admit or retain a resident who is in need of greater services than the facility can provide. (I, II, III)

c. No residential care facility shall admit more residents than the number of beds for which the facility is licensed. (II, III)

d. A residential care facility is not required to admit an individual through court order, referral or other means without the express prior approval of the administrator. (III)

e. The admission of a resident shall not grant the residential care facility the authority or responsibility to manage the personal affairs of the resident except as may be necessary for the safety of the resident and the safe and orderly management of the residential care facility as required by these rules. (III)

f. Individuals under the age of 18 shall not be admitted to a residential care facility without prior written approval by the department. A distinct part of a residential care facility, segregated from the adult section, may be established based on a résumé of care that is submitted by the licensee or applicant and is commensurate with the needs of the residents of the residential care facility and that has received the department’s review and approval. (III)
g. No health care facility and no owner, administrator, employee or representative thereof shall act as guardian, trustee, or conservator for any resident’s property unless such resident is related within the third degree of consanguinity to the person acting as guardian. (III)

63.10(2) Discharge or transfer.

a. Notification shall be made to the legal representative, primary care provider, psychiatrist, if any, and sponsoring agency, if any, prior to the transfer or discharge of any resident. (III)

b. The licensee shall not refuse to discharge or transfer a resident when the primary care provider, family, resident, or legal representative requests such transfer or discharge. (II, III)

c. Advance notification will be made to the receiving facility prior to the transfer of any resident. (III)

d. When a resident is transferred or discharged, the appropriate record will accompany the resident to ensure continuity of care. “Appropriate record” includes the resident’s face sheet, service plan, most recent orders of the primary care provider and any notifications of upcoming scheduled appointments. (II, III)

e. When a resident is transferred or discharged, the resident’s unused prescriptions shall be sent with the resident or with a legal representative only upon the written order of a primary care provider. (II, III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.11(135C) Involuntary discharge or transfer.

63.11(1) Involuntary discharge or transfer permitted. A facility may involuntarily discharge or transfer a resident for only one of the following reasons:

a. Medical reasons;

b. The resident’s welfare or that of other residents;

c. Repeated refusal by the resident to participate in the resident’s service plan;

d. Due to action pursuant to Iowa Code chapter 229; or

e. Nonpayment for the resident’s stay, as described in the residency agreement for the resident’s stay.

63.11(2) Medical reasons. Medical reasons for transfer or discharge shall be based on the resident’s needs and shall be determined and documented in the resident’s record by the primary care provider. Transfer or discharge may be required in order to provide a different level of care to the resident. (II)

63.11(3) Welfare of a resident. Welfare of a resident or that of other residents refers to a resident’s social, emotional, or physical well-being. A resident may be transferred or discharged because the resident’s behavior poses a continuing threat to the resident (e.g., suicidal) or to the well-being of other residents or staff (e.g., the resident’s behavior is incompatible with other residents’ needs and rights). Written documentation that the resident’s continued presence in the facility would adversely affect the resident’s own welfare or that of other residents shall be made by the administrator or designee and shall include specific information to support this determination. (II)

63.11(4) Notice. Involuntary transfer or discharge of a resident from a facility shall be preceded by a written notice to the resident and the responsible party. (II, III)

a. The notice shall contain all of the following information:

(1) The stated reason for the proposed transfer or discharge. (II)

(2) The effective date of the proposed transfer or discharge. (II)

(3) A statement, in not less than 12-point type, that reads as follows: (II)
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 Iowa department of inspections and appeals (hereinafter referred to as “department”) within 7 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. If you request a hearing, it will be held no later than 14 days after receipt of your request by the department and you will not be transferred prior to a final decision. In emergency circumstances, extension of the 14-day requirement may be permitted upon request to the department’s designee. If you lose the hearing, you will not be transferred before the expiration of (1) 30 days following receipt of the original notice of the discharge or transfer, or (2) 5 days following final decision of such hearing, including exhaustion of all appeals, whichever occurs later. To request a hearing or receive further information, call the department at (515)281-4115, or write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083.

b. The notice shall be personally delivered to the resident and a copy placed in the resident’s record. A copy shall also be transmitted to the department; the resident’s responsible party; the resident’s primary care provider; and the person or agency responsible for the resident’s placement, maintenance, and care in the facility. The notice shall indicate that a copy has been transmitted to the required parties by using the abbreviation “cc:” and listing the names of all parties to whom copies were sent. (II)

c. The notice required by paragraph 63.11(4)“a” shall be provided at least 30 days in advance of the proposed transfer or discharge unless one of the following occurs: (II)

  (1) An emergency transfer or discharge is mandated by the resident’s health care needs and is in accordance with the written orders and medical justification of the primary care provider. Emergency transfers or discharges may also be mandated in order to protect the health, safety, or well-being of other residents and staff from the resident being transferred. (II)

  (2) The transfer or discharge is subsequently agreed to by the resident or the resident’s responsible party, and notification is given to the responsible party, the resident’s primary care provider, and the person or agency responsible for the resident’s placement, maintenance, and care in the facility.

  d. A hearing requested pursuant to this subrule shall be held in accordance with subrule 63.11(6).

63.11(5) Emergency transfer or discharge. In the case of an emergency transfer or discharge, the resident must be given a written notice prior to or within 48 hours following transfer or discharge. (II, III)

a. A copy of this notice must be placed in the resident’s file. The notice must contain all of the following information:

  (1) The stated reason for the transfer or discharge. (II)

  (2) The effective date of the transfer or discharge. (II)

  (3) A statement, in not less than 12-point type, that reads: (II)
b. The notice shall be personally delivered to the resident and a copy placed in the resident’s record. A copy shall also be transmitted to the department; the resident’s responsible party; the resident’s primary care provider; and the person or agency responsible for the resident’s placement, maintenance, and care in the facility. The notice shall indicate that a copy has been transmitted to the required parties by using the abbreviation “cc:” and listing the names of all parties to whom copies were sent. (II)

c. A hearing requested pursuant to this subrule shall be held in accordance with subrule 63.11(6).

63.11(6) Hearing.

a. Request for hearing.
   (1) The resident must request a hearing within 7 days of receiving the written notice.
   (2) The request must be made to the department, either in writing or verbally.

b. The hearing shall be held no later than 14 days after receipt of the request by the department unless the resident requests an extension due to emergency circumstances.

c. Except in the case of an emergency discharge or transfer, a request for a hearing shall stay a transfer or discharge pending a final decision, including the exhaustion of all appeals. (II)

d. The hearing shall be heard by a department of inspections and appeals administrative law judge pursuant to Iowa Code chapter 17A and 481—Chapter 10. The hearing shall be public unless the resident or the resident’s legal representative requests in writing that the hearing be closed. In a determination as to whether a transfer or discharge is authorized, the burden of proof by a preponderance of evidence rests on the party requesting the transfer or discharge.

e. Notice of the date, time, and place of the hearing shall be sent by certified mail or delivered in person to the facility, the resident, the responsible party, and the office of the long-term care ombudsman not later than 5 full business days after receipt of the request. The notice shall also inform the facility and the resident or the responsible party that they have a right to appear at the hearing in person or be represented by an attorney or other individual. The appeal shall be dismissed if neither party is present or represented at the hearing. If only one party appears or is represented, the hearing shall proceed with one party present. A representative of the office of the long-term care ombudsman shall have the right to appear at the hearing.

f. The administrative law judge’s written decision shall be mailed by certified mail to the licensee, resident, responsible party, and the office of the long-term care ombudsman within 10 working days after the hearing has been concluded.

63.11(7) Nonpayment. If nonpayment is the basis for involuntary transfer or discharge, the resident shall have the right to make full payment up to the date that the discharge or transfer is to be made and then shall have the right to remain in the facility. (II)

63.11(8) Discussion of involuntary transfer or discharge. Within 48 hours after notice of involuntary transfer or discharge has been received by the resident, the facility shall discuss the involuntary transfer or discharge with the resident, the resident’s responsible party, and the person or agency responsible for the resident’s placement, maintenance, and care in the facility. (II)

a. The facility administrator or other appropriate facility representative serving as the administrator’s designee shall provide an explanation and discussion of the reasons for the resident’s involuntary transfer or discharge. (II)

b. The content of the explanation and discussion shall be summarized in writing, shall include the names of the individuals involved in the discussion, and shall be made part of the resident’s record. (II)

c. The provisions of this subrule do not apply if the involuntary transfer or discharge has already occurred pursuant to subrule 63.11(5) and emergency notice is provided within 48 hours.

63.11(9) Transfer or discharge planning.

a. The facility shall develop a plan to provide for the orderly and safe transfer or discharge of each resident to be transferred or discharged. (II)

b. To minimize the possible adverse effects of the involuntary transfer, the resident shall be offered counseling services by the sending facility before the involuntary transfer and by the receiving facility after the involuntary transfer. Counseling, if accepted, shall be provided by a licensed mental health professional as defined in Iowa Code section 228.1(6). Counseling shall be documented in the resident’s record. (II)
63.11(10) Transfer upon revocation of license or voluntary closure. Residents shall not have the right to a hearing to contest an involuntary discharge or transfer resulting from the revocation of the facility’s license by the department of inspections and appeals. In the case of the voluntary closure of a facility, a period of 30 days must be allowed for an orderly transfer of residents to other facilities.

63.11(11) Intrafacility transfer.

a. Residents shall not be arbitrarily relocated from room to room within a licensed health care facility. (I, II) Involuntary relocation may occur only in the following situations, which shall be documented in the resident’s record: (II)
   (1) Incompatibility with or disturbing to other roommates.
   (2) For the welfare of the resident or other residents of the facility.
   (3) To allow a new admission to the facility that would otherwise not be possible due to separation of roommates by sex.
   (4) In the case of a resident whose source of payment was previously private, but who now is eligible for Title XIX (Medicaid) assistance, the resident may be transferred from a private room to a semiprivate room or from one semiprivate room to another.
   (5) Reasonable and necessary administrative decisions regarding the use and functioning of the building.

b. Unreasonable and unjustified reasons for changing a resident’s room without the concurrence of the resident or responsible party include:
   (1) Change from private pay status to Title XIX, except as outlined in subparagraph 63.11(11)“a’”(4). (II)
   (2) As punishment or behavior modification, except as specified in subparagraph 63.11(11)“a’”(1). (II)
   (3) Discrimination on the basis of race or religion. (II)

c. If intrafacility relocation is necessary for reasons outlined in paragraph 63.11(11)“a,” the resident shall be notified at least 48 hours prior to the transfer and the reason therefor shall be explained. The responsible party shall be notified as soon as possible. The notification shall be documented in the resident’s record and signed by the resident or responsible party. (II, III)

d. If emergency relocation is required in order to protect the safety or health of the resident or other residents, the notification requirements may be waived. The conditions of the emergency shall be documented. The family or responsible party shall be notified immediately or as soon as possible of the condition that necessitates emergency relocation, and such notification shall be documented. (II, III)

e. A transfer to a part of a facility that has a different license must be handled the same way as a transfer to another facility, and not as an intrafacility transfer. (II, III)

481—63.12(135C) Residency agreement.

63.12(1) Each residency agreement shall:

a. State the base rate or scale per day or per month, the services included, and the method of payment. (III)

b. Contain a complete schedule of all offered services for which a fee may be charged in addition to the base rate. (III) Furthermore, the agreement shall:
   (1) Stipulate that no further additional fees shall be charged for items not contained in the complete schedule of services; (III)
   (2) State the method of payment for additional charges; (III)
(3) Contain an explanation of the method of assessment of such additional charges and an explanation of the method of periodic reassessment, if any, resulting in changing such additional charges; (III)

(4) State that additional fees may be charged to the resident for nonprescription drugs, other personal supplies, and services provided by a barber, beautician, and such. (III)

c. Contain an itemized list of services to be provided to the resident based on an assessment at the time of the resident’s admission and in consultation with the administrator and including the specific fee the resident will be charged for each service and the method of payment. (III)

d. Include the total fee to be charged initially to the resident. (III)

e. State the conditions whereby the facility may make adjustments to its overall fees for resident care as a result of changing costs. (II, III) Furthermore, the agreement shall provide that the facility shall give:

(1) Written notification to the resident, or the responsible party when appropriate, of changes in the overall rates of both base and additional charges at least 30 days prior to the effective date of such changes; (II, III)

(2) Notification to the resident, or the responsible party when appropriate, of changes in additional charges, based on a change in the resident’s condition. Notification must occur prior to the date such revised additional charges begin. If notification is given orally, subsequent written notification must also be given within a reasonable time, not to exceed one week, listing specifically the adjustments made. (II, III)

f. State the terms of agreement in regard to a refund of all advance payments in the event of the transfer, death, or voluntary or involuntary discharge of the resident. (II, III)

g. State the terms of agreement concerning the holding of and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons. The terms shall contain a provision that the bed will be held at the request of the resident or the resident’s responsible party. (II, III)

(1) The facility shall ask the resident or responsible party whether the resident’s bed should be held. This request shall be made before the resident leaves or within 48 hours after the resident leaves. The inquiry and the response shall be documented. (II, III)

(2) The facility shall inform the resident or responsible party that, when requested, the bed may be held beyond the number of days designated by the funding source, as long as payments are made in accordance with the agreement. (II, III)

h. State the conditions under which the involuntary discharge or transfer of a resident would be effected. (II, III)

i. Set forth any other matters deemed appropriate by the parties to the agreement. No agreement or any provision thereof shall be drawn or construed so as to relieve any health care facility of any requirement or obligation imposed upon it by this chapter or any standards or rules in force pursuant to this chapter. (II, III)

63.12(2) Each party to the residency agreement shall be provided a copy of the signed agreement. (II, III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.13(135C) Medical examinations.

63.13(1) Each resident in a residential care facility shall have a designated primary care provider who may be contacted when needed. (II, III)

63.13(2) Each resident admitted to a residential care facility shall have a physical examination prior to admission. (II, III)

a. If the resident is admitted directly from a hospital, a copy of the hospital admission physical and discharge summary may be a part of the record in lieu of an additional physical examination. A record of the examination, signed by the primary care provider, shall be a part of the resident’s record. (II, III)
b. The record of the admission physical examination and medical history shall portray the current medical status of the resident and shall include the resident’s name, sex, age, medical history, physical examination, diagnosis, statement of medical concerns, and results of any diagnostic procedures. (II, III)

c. Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59. (I, II, III)

63.13(3) The person in charge shall immediately notify the primary care provider of any accident, injury or adverse change in the resident’s condition that has the potential for requiring further medical treatment. (I, II, III)

63.13(4) Each resident shall be visited by or shall visit the resident’s primary care provider at least once each year. The one-year period shall be measured from the date of admission and does not include the resident’s preadmission physical. (III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.14(135C) Records.

63.14(1) Resident record. The licensee shall keep a permanent record on all residents admitted to a specialized residential care facility with all entries current, dated, and signed. (III) The record shall include:

a. Name and previous address of resident; (III)

b. Birth date, sex, and marital status of resident; (III)

c. Church affiliation; (III)

d. Primary care provider’s name, telephone number, and address; (III)

e. Dentist’s name, telephone number, and address; (III)

f. Name, address, and telephone number of next of kin or legal representative; (III)

g. Name, address, and telephone number of person to be notified in case of emergency; (III)

h. Mortuary’s name, telephone number, and address; (III)

i. Pharmacist’s name, telephone number, and address; (III)

j. Physical examination and medical history; (III)

k. Certification by the primary care provider that the resident requires no more than personal care and supervision, but does not require nursing care; (III)

l. Primary care provider’s orders for medication, treatment, and diet in writing and signed by the primary care provider; (III)

m. A notation of yearly or other visits to primary care provider or other professional services; (III)

n. Any change in the resident’s condition; (II, III)

o. If the primary care provider has certified that the resident is capable of taking prescribed medications, the resident shall be required to keep the administrator advised of current medications, treatments, and diet. The administrator shall keep a listing of medication, treatments, and diet prescribed by the primary care provider for each resident; (III)

p. If the primary care provider has certified that the resident is not capable of taking prescribed medication, it must be administered by a qualified person of the facility. A qualified person shall be defined as either a registered or licensed practical nurse or an individual who has completed the state-approved training course in medication administration, including a medication manager or certified medication aide; (II)

q. Medications administered by an employee of the facility shall be recorded on a medication record by the individual who administers the medication; (II, III)

r. A notation describing the resident’s condition on admission, transfer, and discharge; (III)

s. In the event of a resident’s death, notations in the resident’s record shall include the date and time of the resident’s death, the circumstances of the resident’s death, the disposition of the resident’s body, and the date and time that the resident’s family and primary care provider were notified of the resident’s death; (III)

t. A copy of instructions given to the resident, legal representative, or facility in the event of discharge or transfer; (III)

u. Disposition of valuables; (III)
v. Current individual program plans. (II, III)  

63.14(2) Confidentiality of resident records.  
   a. Each resident shall be ensured confidential treatment of all information contained in the resident’s records. The resident’s written consent shall be required for the release of information to persons not otherwise authorized under law to receive it. (II)  
   b. The facility shall limit access to any medical records to staff and consultants providing professional service to the resident. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)  
   c. Similar procedures shall safeguard the confidentiality of residents’ personal records, e.g., financial records and social services records. Only those personnel concerned with the financial affairs of the residents may have access to the financial records. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)  
   d. The resident or the resident’s responsible party shall be entitled to examine all information contained in the resident’s record and shall have the right to secure full copies of the record at reasonable cost upon request, unless the primary care provider determines the disclosure of the record or section thereof is contraindicated in which case this information will be deleted before the record is made available to the resident or responsible party. This determination and the reasons for it must be documented in the resident’s record. (II)  

63.14(3) Incident record.  
   a. Each residential care facility shall maintain an incident record report and shall have available incident report forms. (II, III)  
   b. Report of incidents shall be in detail on an incident report form. (III)  
   c. The person in charge at the time of the incident shall oversee the preparation of and sign the incident report. The administrator or designee shall review, sign and date the incident report within 72 hours of the accident, incident or unusual occurrence. (II, III)  
   d. An incident report shall be completed for every accident or incident where there is apparent injury or where an injury of unknown origin may have occurred. (II)  
   e. An incident report shall be completed for every accident, incident or unusual occurrence within the facility or on the premises that affects a resident, visitor, or employee. (II, III)  
   f. A copy of the incident report shall be kept on file in the facility. (II, III)  

63.14(4) Retention of records.  
   a. Records shall be retained in the facility for five years following the termination of services to a resident. (III)  
   b. Records shall be retained within the facility upon change of ownership. (III)  
   c. When the facility ceases to operate, a copy of the resident’s record shall be released to the facility to which the resident is transferred. (III)  
   d. When the facility ceases to operate, records shall be maintained for five years in a clean, dry secured storage area. (III)  

63.14(5) Electronic records. In addition to the access provided in 481—subrule 50.10(2), an authorized representative of the department shall be provided unrestricted access to electronic records pertaining to the care provided to the residents of the facility. (II, III)  
   a. If access to an electronic record is requested by the authorized representative of the department, the facility may provide a tutorial on how to use its particular electronic system or may designate an individual who will, when requested, access the system, respond to any questions or assist the authorized representative as needed in accessing electronic information in a timely fashion. (II, III)  
   b. The facility shall provide a terminal where the authorized representative may access records. (II, III)  
   c. If the facility is unable to provide direct print capability to the authorized representative, the facility shall make available a printout of any record or part of a record on request in a time frame that does not intentionally prevent or interfere with the department’s survey or investigation. (II, III)  

63.14(6) Reports to the department. The licensee shall furnish statistical information concerning the operation of the facility to the department on request. (III)
63.14(7) Personnel record.
   a. Personnel records for each employee shall be kept in accordance with subrule 63.8(4). (III)
   b. The personnel records shall be made available for review upon request by the department. (III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.15(135C) Resident care and personal services.

63.15(1) A complete change of bed linens shall be provided at least once a week and more often if necessary. (III)
63.15(2) Residents shall receive sufficient supervision to promote personal cleanliness. (II, III)
63.15(3) Residents shall have clean clothing as needed. Clothing shall be appropriate to residents’ activities and to the weather. (III)
63.15(4) Residents shall be encouraged to bathe at least twice a week. (II, III)
63.15(5) All nonambulatory residents shall be housed on the grade level floor unless the facility has a suitably sized elevator. (II)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.16(135C) Drugs.

63.16(1) Drug storage.

   a. Residents who have been certified in writing by their primary care provider as capable of taking their own medications may retain these medications in their bedroom, but locked storage must be provided, with staff and the resident having access, and the drug storage shall be kept locked when not in use. Monitoring of the storage, administration, and documentation by the resident shall be carried out by a person who meets the requirements of subrule 63.16(3) and is responsible for administering medications. (II, III)
   b. Drug storage for residents who are unable to take their own medications and require supervision shall meet the following requirements:
      (1) Locked storage for drugs, solutions, and prescriptions shall be provided. (III)
      (2) A bathroom shall not be used for drug storage. (III)
      (3) The drug storage shall be kept locked when not in use. (III)
      (4) The drug storage key shall be secured and available only to those employees charged with the responsibility of administering medications. (II, III)
      (5) Schedule II drugs, as defined by Iowa Code chapter 124, shall be kept in a locked box within the locked drug storage. (II, III)
      (6) Medications requiring refrigeration shall be kept locked in a refrigerator and separated from food and other items. (II, III)
      (7) Drugs for external use shall be stored separately from drugs for internal use. (II, III)
      (8) All potent, poisonous, or caustic materials shall be stored separately from drugs, shall be plainly labeled and stored in a specific, well-illuminated cabinet, closet, or storeroom, and shall be made accessible only to authorized persons. (I, II)
      (9) Inspection of drug storage shall be made by the administrator or designee and a registered pharmacist not less than once every three months. The inspection shall be verified by a report signed by the administrator and the pharmacist and filed with the administrator. The report shall include, but not be limited to, certification of the absence of the following: expired drugs, deteriorated drugs, improper labeling, drugs for which there is no current primary care provider’s order, and drugs improperly stored. (III)
      (10) Bulk supplies of prescription drugs for multiresident use shall not be kept in a residential care facility. (III)

63.16(2) Drug safeguards.

   a. All prescribed medications shall be clearly labeled indicating the resident’s full name, primary care provider’s name, prescription number, name and strength of drug, dosage, directions for use, date of issue, and name and address and telephone number of pharmacy or primary care provider issuing the drug. Where unit dose is used, prescribed medications shall, at a minimum, indicate the resident’s
full name, primary care provider’s name, name and strength of drug, and directions for use. Standard containers shall be utilized for dispensing drugs. (III)

b. Sample medications provided by the resident’s primary care provider shall clearly identify to whom the medications belong. (III)

c. Medication containers having soiled, damaged, illegible, or makeshift labels shall be returned to the issuing pharmacist, pharmacy, or primary care provider for relabeling or disposal. (III)

d. The medication for each resident shall be kept or stored in the original containers unless the resident is participating in an individualized medication program. (II, III)

e. Unused prescription drugs shall be destroyed by the person in charge, in the presence of a witness, and with a notation made on the resident’s record or shall be returned to the supplying pharmacist. (III)

f. Prescriptions shall be refilled only with the permission of the resident’s primary care provider. (II, III)

g. Medications prescribed for one resident shall not be administered to or allowed in the possession of another resident. (I, II)

h. Instructions shall be requested from the Iowa board of pharmacy concerning disposal of unused Schedule II drugs prescribed for a resident who has died or for whom the Schedule II drug was discontinued. (III)

i. Discontinued medications shall be destroyed within a specified time by a responsible person, in the presence of a witness, and with a notation made to that effect or shall be returned to the pharmacist for destruction. Drugs listed under the Schedule II drugs shall be destroyed in accordance with the requirements established by the Iowa board of pharmacy. (II, III)

j. All medication orders which do not specifically indicate the number of doses to be administered or the length of time the drug is to be administered shall be stopped automatically after a given time period. The automatic-stop order may vary for different types of drugs. The resident’s primary care provider, in conjunction with the pharmacist, shall institute these policies and provide procedures for review and endorsement. (II, III)

k. No resident shall be allowed to possess any medications unless the primary care provider has certified in writing on the resident’s medical record that the resident is mentally and physically capable of doing so. (II)

l. No medications or prescription drugs shall be administered to a resident without a written order signed by the primary care provider. (II)

m. The facility shall establish a policy to govern the distribution of prescribed medications to residents who are on leave from the facility. (II, III)

(1) Medications may be issued to residents who will be on leave from a facility for less than 24 hours. Only those medications needed for the time period that the resident will be on leave from the facility may be issued. Non-child-resistant containers may be used. Instructions shall be provided and include the date, the resident’s name, the name of the facility, and the name of the medication, its strength, dose and time of administration. (II, III)

(2) Medication for residents on leave from a facility for longer than 24 hours shall be obtained in accordance with requirements established by the Iowa board of pharmacy. (II, III)

(3) Medication for residents on leave from a facility may be issued only by facility personnel responsible for administering medication. (II, III)

63.16(3) Drug administration—authorized personnel.

a. A properly trained person shall be charged with the responsibility of administering medications as ordered by a primary care provider. (II, III)

b. The person shall have knowledge of the purpose of the drugs and their dangers and contraindications. (II, III)

c. The person shall be a licensed nurse or primary care provider or an individual who has completed the state-approved training course in medication administration, including a medication manager or certified medication aide. (II, III)
d. Prior to taking a department-approved medication aide course, the person shall have a letter of recommendation for admission to the medication aide course from the employing facility. (III)

e. A person who is a nursing student or a graduate nurse may take the medication aide challenge examination in place of taking a course. The person shall do all of the following before taking the challenge examination:

(1) Complete a clinical or nursing theory course within six months before taking the challenge examination; (III)

(2) Successfully complete a nursing program pharmacology course within one year before taking the challenge examination; (III)

(3) Provide to the community college a written statement from the nursing program’s pharmacology or clinical instructor indicating that the person is competent in medication administration. (III)

f. A person who has written documentation of certification as a medication aide in another state may become a medication aide in Iowa by successfully completing a department-approved nurse aide competency examination and a medication aide challenge examination. The requirements of paragraph 63.16(3) “d” do not apply to this person. (III)

63.16(4) Drug administration.

a. Unless the unit dose system is used, the person assigned the responsibility of medication administration must complete the procedure by personally preparing the dose, observing the actual act of swallowing the oral medication, and charting the medication. In facilities where the unit dose system is used, the person assigned the responsibility of medication administration must complete the procedure by observing the actual act of swallowing the oral medication and by charting the medication. Medications shall be prepared on the same shift of the same day that they are administered unless the unit dose system is used. (II)

b. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, primary care provider or pharmacist. For purposes of this subrule, “injectable medications” does not include an epinephrine autoinjector, e.g., an EpiPen. (II, III)

c. A resident certified by the resident’s primary care provider as capable of injecting the resident’s own insulin may do so. Insulin may be administered pursuant to paragraph 63.16(4) “b” or as otherwise authorized by the resident’s primary care provider. (II, III) Authorization shall:

(1) Be in writing,
(2) Be maintained in the resident’s record,
(3) Be renewed quarterly,
(4) Include the name of the person authorized to administer the insulin,
(5) Include documentation by the primary care provider that the authorized person is qualified to administer insulin to that resident. (II, III)

d. A resident may participate in the administration of the resident’s own medication if the primary care provider has certified in writing in the resident’s medical record that the resident is mentally and physically capable of participating and has explained in writing in the resident’s medical record what the resident’s participation may include.

e. An individual inventory record shall be maintained for each Schedule II drug prescribed for each resident, with an accurate count and authorized signatures at every shift. (II)

f. The facility may use a unit dose system.

g. Medication aides and medication managers may administer PRN medications without contacting a licensed nurse or primary care provider if all of the following apply: (I, II, III)

(1) A written order from the resident’s primary care provider specifies the purpose of the PRN medication and the frequency, dosage and strength of the PRN medication.

(2) The resident’s primary care provider provides in writing specific criteria for administering PRN medications.

(3) The pharmacist assesses the resident’s use of PRN medications when conducting the inspection of drug storage as required by subparagraph 63.16(1) “b” (9).

h. The pharmacist shall assess the use of PRN medications when conducting the inspection of drug storage as required by subparagraph 63.16(1) “b” (9). (II, III)
i. Medications administered by an employee of the facility shall be recorded on a medication record by the individual who administers the medication. (I, II, III) [ARC 3740C, IAB 4/11/18, effective 5/16/18; ARC 4577C, IAB 7/31/19, effective 9/4/19]

481—63.17(135C) Dental services.

63.17(1) The residential care facility personnel shall assist residents in obtaining annual and emergency dental services and shall arrange transportation for such services. (III)

63.17(2) Dental services shall be performed only on the request of the resident, responsible party, legal representative, or primary care provider. The resident’s primary care provider shall be advised of the resident’s dental problems. (III)

63.17(3) All dental reports or progress notes shall be included in the resident record as available. The facility shall make reasonable efforts to obtain the records following the provision of services. (III)

63.17(4) Personal care staff shall assist the resident in carrying out the dentist’s recommendations. (III) [ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.18(135C) Dietary.

63.18(1) Dietary staffing. Personnel who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. (III)

63.18(2) Nutrition and menu planning.

a. Menus shall be planned and followed to meet the nutritional needs of residents in accordance with the primary care provider’s orders. Diet orders should be reviewed as necessary, but at least quarterly, by the primary care provider. (II, III)

b. In facilities where residents plan and prepare their own meals, education and support shall be provided to residents regarding proper food preparation, dietary guidelines, and food safety.

c. In facilities where food is regularly prepared for residents, the following shall apply:

(1) Menus shall be planned and served to include foods and amounts necessary to meet federal dietary guidelines. (II, III)

(2) At least three meals or their equivalent shall be offered daily, at regular hours. (II, III)

1. There shall be no more than a 14-hour span between offering a substantial evening meal and breakfast. (II, III)

2. Unless contraindicated, evening snacks shall be offered routinely to all residents. Special nourishments shall be available when ordered by the primary care provider. (II, III)

(3) Menus shall include a variety of foods prepared in various ways. (III)

(4) Menus shall be written at least one week in advance. The current menu shall be located in an accessible place for easy use by persons purchasing, preparing, and serving food. (III)

(5) Records of menus as served shall be filed and maintained for 30 days and shall be available for review by departmental personnel. When substitutions are necessary or requested, they shall be of similar nutritive value and recorded on the menu or in a notebook. (III)

(6) The facility shall provide an alternative choice at scheduled meal times. (III)

63.18(3) Dietary storage, food preparation, and service.

a. All food shall be handled, prepared, served and stored in compliance with the Food Code adopted pursuant to Iowa Code section 137F.2. (I, II, III)

b. Supplies of staple foods for a minimum of a one-week period and of perishable foods for a minimum of a two-day period shall be maintained on the premises. Minimum food portion requirements for a low-cost plan shall conform to information supplied by the bureau of nutrition and health promotion of the department of public health. (II, III)

c. Dishes shall be free of cracks, chips, and stains. (III)
\textit{d.} If family-style service is used, all leftover prepared food that has been on the table shall be properly handled. (III)

\textbf{63.18(4) Sanitation in food preparation area.} There shall be written procedures established for cleaning all work and serving areas. (III)

\[\text{ARC 3740C, IAB 4/11/18, effective 5/16/18}\]

\textbf{481—63.19(135C) Orientation and service plan.}

\textbf{63.19(1) Orientation.} Within 24 hours of admission, each resident shall receive orientation to the facility. The orientation program shall be documented in the resident’s file and shall include, but shall not be limited to, a review of the resident’s rights, the daily schedule, house rules and the facility’s evacuation plan. (II, III)

\textbf{63.19(2) Initial service plan.} Within 48 hours of admission, the administrator or the administrator’s designee shall develop an initial service plan to address any immediate health and safety needs. The plan shall be based on information gathered from the resident, family, referring party, primary care provider, and other significant persons. The plan shall be followed until the service plan required in subrule 63.19(3) is complete. (I, II, III)

\textbf{63.19(3) Service plan.} Within 30 days of admission, the administrator or the administrator’s designee, in conjunction with the resident and the resident’s interdisciplinary team, shall develop a written, individualized, and integrated service plan for the resident. The service plan shall be developed and implemented to address the resident’s priorities and assessed needs, such as activities of daily living, rehabilitation, activity, and social, behavioral, emotional, physical and mental health. (I, II, III)

\begin{itemize}
\item \textit{a.} The service plan shall include measurable goals and objectives and the specific service(s) to be provided to achieve the goals. Each goal shall include the date of initiation and anticipated duration of service(s). Any restriction of rights shall be included in the service plan. (I, II, III)
\item \textit{b.} The service plan shall include the documentation procedure for each goal and objective. (II, III)
\item \textit{c.} The service plan should be modified to add or delete goals and objectives as the resident’s needs change. Communications related to service plan changes or changes in the resident’s condition shall occur within five working days of the change and shall be conveyed to all individuals inside and outside the residential care facility who work with the resident, as well as to the resident’s responsible party. (I, II, III)
\item \textit{d.} The service plan shall be reviewed at least quarterly by relevant staff, the resident and appropriate others, such as the resident’s family, case manager and responsible party. The review shall include a written report which addresses a summary of the resident’s progress toward goals and objectives and the need for continued services. (I, II, III)
\end{itemize}

\[\text{ARC 3740C, IAB 4/11/18, effective 5/16/18}\]

\textbf{481—63.20(135C) Resident activities program.}

\textbf{63.20(1) Activities program.} Each residential care facility shall provide suitable group and individual activities for residents. (III)

\begin{itemize}
\item \textit{a.} The activities provided shall be designed to meet the needs and interests of each resident and to assist residents in continuing normal activities within limitations set by the resident’s primary care provider. This shall include helping residents continue in their individual interests or hobbies. (III)
\item \textit{b.} Residents shall be encouraged, but not required, to participate in activities. (III)
\item \textbf{63.20(2)} Each resident may participate in activities of social, religious, and community groups at the resident’s discretion unless contraindicated for reasons documented by the primary care provider or interdisciplinary team as appropriate in the resident’s record. (II)
\item \textbf{63.20(3)} Residents who wish to meet with or participate in activities of social, religious, or other community groups in or outside of the facility shall be informed, encouraged, and assisted to do so. (II)
\item \textbf{63.20(4) Supplies, equipment, and storage.}
\begin{itemize}
\item \textit{a.} Each facility shall provide a variety of supplies and equipment of a nature calculated to fit the needs and interests of the residents. (III)
\end{itemize}

\[\text{ARC 3740C, IAB 4/11/18, effective 5/16/18}\]
b. Storage shall be provided for recreational equipment and supplies. (III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.21(135C) Residents’ rights.

63.21(1) Each facility shall ensure that policies and procedures are written and implemented which include, at a minimum, the provisions of this rule and which govern all areas of service provided by the facility. These policies and procedures shall be available to staff, residents, residents’ families or legal representatives and the public and shall be reviewed annually. (II, III)

63.21(2) Policies and procedures shall include a method for submitting complaints and recommendations by residents or their responsible parties and for ensuring a response and disposition by the facility. (II, III) The written procedures shall:

a. Ensure the provision of assistance to residents as necessary to complete and submit complaints and recommendations; (II, III)

b. Ensure protection of the resident from any form of reprisal or intimidation; (II, III)

c. Include designation of an employee responsible for handling grievances and recommendations; (II, III)

d. Include a method of investigating and assessing the validity of a grievance or recommendation; (II, III) and

e. Include methods of recording grievances and actions taken. (II, III)

63.21(3) Policies and procedures shall include provisions governing access to, duplication of, and dissemination of information from the residents’ records. (II, III)

63.21(4) Policies and procedures shall include a provision that each resident shall be fully informed of the resident’s rights and responsibilities as a resident and of all rules governing resident conduct and responsibilities. This information must be provided upon the resident’s admission or, in the case of residents already in the facility, upon the facility’s adoption or amendment of residents’ rights policies. (II, III)

a. The facility shall communicate to residents prior to or within five days after admission what residents may expect from the facility and its staff and what is expected from residents. The communication shall be in writing, e.g., in a separate handout or brochure describing the facility, and interpreted verbally, e.g., as part of a preadmission interview, resident counseling, or in individual or group orientation sessions following the resident’s admission. (II, III)

b. Residents’ rights and responsibilities shall be presented in language understandable to the resident. If the facility serves residents who are non-English-speaking or deaf, steps shall be taken to translate the information into a foreign or sign language. In the case of blind residents, either Braille or a recording shall be provided. Residents shall be encouraged to ask questions about their rights and responsibilities, and these questions shall be answered. (II, III)

c. A statement shall be signed by the resident, or the resident’s responsible party if applicable, indicating an understanding of these rights and responsibilities and shall be maintained in the resident’s record. The statement shall be signed no later than five days after admission, and a copy of the signed statement shall be given to the resident or responsible party. (II, III)

d. In order to ensure that residents continue to be aware of these rights and responsibilities during their stay, a written copy shall be prominently posted in a location that is available to all residents. (II, III)

e. All residents shall be advised within 30 days following changes made in the statement of residents’ rights and responsibilities. Appropriate means shall be utilized to inform non-English-speaking, deaf or blind residents of changes. (II, III)

63.21(5) Choice of primary care provider. Each resident shall be permitted free choice of a primary care provider, and pharmacy, if accessible. The facility may require the selected pharmacy to utilize a drug distribution system compatible with the system currently used by the facility. (II)

63.21(6) Each resident shall be afforded the opportunity to participate in the planning of the resident’s total care and treatment, which may include, but shall not be limited to, medical care, nutritional needs, activities, and social work services. Each resident has the right to refuse treatment
except as provided by Iowa Code chapter 229. In the case of a resident with a responsible party, the responsible party shall be afforded the opportunity to participate in the planning of the resident’s total care and medical treatment and to be informed of the resident’s medical condition. (II, III)

63.21(7) Each resident shall be encouraged and assisted throughout the resident’s period of stay to exercise the resident’s rights as a resident and as a citizen and may voice grievances and recommend changes in policies and services to administrative staff or to outside representatives of the resident’s choice, free from interference, coercion, discrimination, or reprisal. (II)

63.21(8) The facility shall provide ongoing opportunities for residents to be aware of and to exercise their rights as residents. Residents shall be kept informed of changes in policies and services that are more restrictive, and their views shall be solicited prior to action. (II)

63.21(9) The facility shall post in a prominent area the text of Iowa Code section 135C.46 (Retaliation by facility prohibited) and the name, telephone number, and address of the long-term care ombudsman, the department, and the local law enforcement agency to provide residents a further course of redress. (II)

63.21(10) All rights and responsibilities of the resident devolve to the resident’s responsible party or any legal surrogate designated in accordance with state law, to the extent permitted by state law. This subrule is not intended to limit the authority of any individual acting pursuant to Iowa Code chapter 144A. (II, III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.22(135C) Dignity preserved. The resident shall be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs. (I, II)

63.22(1) Staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings. (I, II)

63.22(2) Schedules of daily activities shall allow maximum flexibility for residents to exercise choice about what they will do and when they will do it. Residents’ individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, entertainment, sleeping and eating, also times to retire at night and arise in the morning shall be elicited and considered by the facility. (II)

63.22(3) Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or a drawn curtain shall shield the resident from passersby. People not involved in the care of the residents shall not be present without the resident’s consent while the resident is being examined or treated. (II)

63.22(4) Privacy of a resident’s body also shall be maintained during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. (II)

63.22(5) Staff shall knock and be acknowledged before entering a resident’s room unless the resident is not capable of a response. This shall not apply under emergency conditions. (II)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.23(135C) Communications. Each resident may communicate, associate, and meet privately with persons of the resident’s choice, unless to do so would infringe upon the rights of other residents, and may send and receive personal mail unopened. (II)

63.23(1) Subject to reasonable scheduling restrictions, visiting policies and procedures shall permit residents to receive visits from anyone they wish. Visiting hours shall be posted. (II)

63.23(2) Reasonable, regular visiting hours shall not be less than 12 hours per day and shall take into consideration the special circumstances of each visitor. A particular visitor(s) may be restricted by the facility for one of the following reasons:

a. The resident refuses to see the visitor(s). (II)

b. The resident’s primary care provider documents specific reasons why such a visit would be harmful to the resident’s health. (II)

c. The visitor’s behavior is unreasonably disruptive to the functioning of the facility. This judgment must be made by the administrator, and the reasons shall be documented and kept on file. (II)
63.23(3) Decisions to restrict a visitor are reviewed and reevaluated:
   a. Each time the medical orders are reviewed by the primary care provider;
   b. At least quarterly by the facility’s staff; or
   c. At the resident’s request. (II)
63.23(4) Space shall be provided for residents to receive visitors in reasonable comfort and privacy. (II)
63.23(5) Telephones shall be available and accessible for residents to make and receive calls with privacy. Residents who need help shall be assisted in using the telephone. (II)
63.23(6) Arrangements shall be made to provide assistance to residents who require help in reading or sending mail. (II)
63.23(7) Residents, including residents court-ordered to the facility, shall be permitted to leave the facility at reasonable times unless there are justifiable reasons established in writing by court order, the primary care provider, the interdisciplinary team, or the facility administrator for refusing permission. (II)
63.23(8) Residents shall not have their personal lives regulated beyond reasonable adherence to meal schedules, bedtime hours, and other written policies which may be necessary for the orderly management of the facility and as required by these rules. However, residents shall be encouraged to participate in recreational programs. (II)
[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.24(135C) Resident property.
63.24(1) Residents shall be permitted to keep reasonable amounts of personal clothing and possessions for their use while in the facility. The facility shall offer the resident the opportunity to have personal property itemized and documented on an inventory sheet upon the resident’s admission. The inventory sheet shall be kept in a safe location which is convenient for the resident to review and update. At discharge, residents may sign off on a list of the personal property they are taking with them. (II, III)
63.24(2) The facility shall provide for the safekeeping of personal effects, funds and other property of its residents. The facility may require that items of exceptional value or that would convey unreasonable responsibilities to the licensee be removed from the premises of the facility for safekeeping. (III)
63.24(3) Any funds or other property belonging to or due a resident, or expendable for the resident’s account, which is received by the facility shall be trust funds; shall be kept separate from the funds and property of the facility and of its other residents, or specifically credited to such resident; and shall be used or otherwise expended only for the account of the resident. (III)
[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.25(135C) Financial affairs—management. Each resident who has not been assigned a guardian or conservator by the court may manage the resident’s own personal financial affairs. To the extent the facility assists in management, under written authorization by the resident, the management shall be carried out in accordance with Iowa Code section 135C.24. (II)
63.25(1) The facility shall maintain a written account of all residents’ funds received by or deposited with the facility. (II)
63.25(2) An employee shall be designated in writing to be responsible for resident accounts. (II)
63.25(3) The facility shall keep on deposit personal funds over which the resident has control in accordance with Iowa Code section 135C.24. Should the resident request these funds, they shall be given to the resident on request with receipts maintained by the facility and a copy to the resident. In the case of a resident with impaired decision-making skills, the resident’s legal representative shall designate a method of disbursing the resident’s funds. (II)
63.25(4) If the facility makes financial transactions on a resident’s behalf, the facility must document that it has prepared and sent an itemized accounting of disbursements and current balances at least quarterly. A copy of this statement shall be maintained in the resident’s financial or business record. (II)
63.25(5) A resident’s personal funds shall not be used without the written consent of the resident or the resident’s legal representative. (I, II)
63.25(6) A resident’s personal funds shall be returned to the resident when the funds have been used without the written consent of the resident or the resident’s legal representative. The department may report findings that resident funds have been used without written consent to the department’s investigations division or to the local law enforcement agency, as appropriate. (II)
[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.26(135C) Resident work. No resident may be required to perform services for the facility, except as provided by Iowa Code section 347B.5. (II)
63.26(1) Residents may not be used to provide a source of labor for the facility against their will. Approval by the primary care provider or physiatrist is required for all work programs. (I, II)
63.26(2) Residents who perform work for the facility must receive compensation unless the work is part of their approved training program. Persons on the resident census who perform work shall not be used to replace paid employees in fulfilling staffing requirements. (II)
[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.27(135C) Resident abuse prohibited. Each resident shall receive kind and considerate care at all times and shall be free from mental, physical, sexual, and verbal abuse, exploitation, neglect, and physical injury. (I, II)
63.27(1) Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation. (I, II)
63.27(2) Physical abuse includes, but is not limited to, corporal punishment and the use of restraints as punishment. (I, II)
63.27(3) Drugs such as tranquilizers shall only be used in accordance with orders of the primary care provider. (I, II)
63.27(4) Allegations of dependent adult abuse. Allegations of dependent adult abuse shall be reported and investigated pursuant to Iowa Code chapter 235E and 481—Chapter 52. (I, II, III)
63.27(5) Staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16. (I, II, III)
[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.28(135C) Crisis intervention. If a facility utilizes physical restraints, the facility shall have written policies that define the uses of physical restraints, designate the administrator or designee as the person who may authorize their use, establish a mechanism for monitoring and controlling their use, and provide staff with proper training. (I, II)
63.28(1) Temporary physical restraint of residents shall be used only under the following conditions: (I, II)
   a. An emergency to prevent injury to the resident or to others; or (I, II)
   b. For crisis intervention, but shall not be used for punishment, for the convenience of staff or as a substitution for supervision or programming; (I, II) and
   c. No staff person shall use any restraint that obstructs the airway of the resident. (I, II)
63.28(2) Authorization for the use of physical restraints must be prior to or immediately after application of the restraint. (I, II)
63.28(3) Prone restraint is prohibited. Staff persons who find themselves involved in the use of a prone restraint when responding to an emergency must take immediate steps to end the prone restraint. (I, II)
63.28(4) The rationale and authorization for the use of physical restraint and staff action and procedures carried out to protect the resident’s rights and to ensure safety shall be clearly set forth in the resident’s record by the responsible staff persons. (I, II)
63.28(5) The primary care provider, the interdisciplinary team and the resident’s responsible party shall be notified of any restraints administered. (I, II, III)
63.28(6) The facility shall provide to the staff a department-approved training program by qualified professionals on physical restraint techniques. (I, II)
a. The facility shall keep a record of training for review by the department and shall include attendance. (II, III)
b. Only staff with documented training in physical restraint and techniques shall be authorized to assist with physical restraint of a resident. (I, II)
c. Under no circumstances shall a resident be allowed to actively or passively assist in the restraint of another resident. (I, II)

63.28(7) Residents shall not be kept behind locked doors. (I, II)
63.28(8) Mechanical restraint is prohibited. Staff persons who find themselves involved in the use of a mechanical restraint when responding to an emergency must take immediate steps to end the mechanical restraint. (I, II)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.29(135C) Safety. The licensee of a residential care facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (I, II, III)

63.29(1) Fire safety.
  a. All residential care facilities shall meet the fire safety rules and regulations as promulgated by the state fire marshal. (I, II)
  b. The size of the facility and needs of the residents shall be taken into consideration in evaluating safety precautions and practices.

63.29(2) Safety duties of administrator. The administrator shall have a written emergency plan to be followed in the event of fire, tornado, explosion, or other emergency. (III)
  a. The plan shall be prominently posted in a common area of the building. (III)
  b. In-service shall be provided to ensure that all employees are knowledgeable of the emergency plan. (II, III)

63.29(3) Resident safety.
  a. Smoking shall be prohibited, except as allowed by Iowa Code chapter 142D, the smokefree air Act. (II, III)
  b. Whenever full or empty tanks of oxygen are being used or stored, they shall be securely supported in an upright position. (II, III)
  c. Residents shall receive adequate supervision to ensure against hazard from themselves, others, or elements in the environment. (I, II, III)
  d. Storage areas for cleaning agents, bleaches, insecticides, or any other poisonous, dangerous, or flammable materials shall be locked. Residents permitted to access these materials shall have an order by their primary care provider stating the resident is able to utilize such materials, and staff shall supervise the residents as identified in the resident’s service plan. (I, II, III)
  e. Sufficient numbers of noncombustible trash containers with covers shall be available. (III)
  f. Residents’ personal possessions that may constitute a hazard to residents or others shall be removed and stored. (III)

63.29(4) First-aid kit. A first-aid emergency kit shall be available on each floor in every facility. (II, III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.30(135C) Housekeeping.

63.30(1) Each resident room shall be cleaned on a routine schedule. (III)
63.30(2) All rooms, corridors, storage areas, linen closets, attics, and basements shall be kept in a clean, orderly condition, free of unserviceable furniture and equipment and accumulations of refuse. (II, III)

63.30(3) A hallway or corridor shall not be used for storage of equipment. (II, III)
63.30(4) All odors shall be kept under control by cleanliness and proper ventilation. (III)
63.30(5) Clothing worn by personnel shall be clean and washable. (III)
63.30(6) All furniture, bedding, linens, and equipment shall be cleaned periodically and before use by another resident. (II, III)
63.30(7) Polishes used on floors shall provide a nonslip finish. (II, III)
63.30(8) Throw or scatter rugs shall have nonskid backing. (II, III)
63.30(9) Entrances, exits, steps, and outside walkways shall be kept free from ice, snow, and other hazards. (II, III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.31(135C) Maintenance.
63.31(1) The building, grounds, and other buildings shall be maintained in a clean, orderly condition and in good repair. (II, III)
63.31(2) Window treatments and furniture shall be clean and in good repair. (II, III)
63.31(3) Cracks in plaster, peeling wallpaper or paint, and tears or splits in floor coverings shall be promptly repaired or replaced in a professional manner. (II, III)
63.31(4) The electrical systems, including appliances, cords, and switches, shall be maintained to guarantee safe functioning and comply with the National Electric Code. (II, III)
63.31(5) All plumbing fixtures shall function properly and comply with the state plumbing code. (II, III)
63.31(6) Yearly inspections of the heating and cooling systems shall be made to guarantee safe operation. (II, III)
63.31(7) The building, grounds, and other buildings shall be kept free of breeding areas for flies, other insects, and rodents. (II, III)
63.31(8) The facility shall be kept free of flies, other insects, and rodents. (II, III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.32(135C) Laundry.
63.32(1) Residents’ personal laundry shall be marked with an identification if commingled with other residents’ personal laundry. (III)
63.32(2) Bed linens, towels, and washcloths shall be clean and stain-free. (III)
63.32(3) If laundry is done in the facility, a clean, dry, well-lit area to accommodate a washer and dryer of adequate size to serve the needs of the facility shall be provided. (III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.33(135C) Garbage and waste disposal.
63.33(1) All garbage shall be gathered, stored, and disposed of in a manner that will not permit transmission of disease, create a nuisance, or provide a breeding or feeding place for vermin or insects. (III)
63.33(2) All containers for refuse shall be watertight and rodent-proof and have tight-fitting covers. (III)
63.33(3) All unlined containers inside of the facility shall be thoroughly cleaned each time the containers are emptied. (III)
63.33(4) All waste shall be properly disposed of in compliance with local ordinances and state codes. (III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.34(135C) Supplies.
63.34(1) Linen supplies.
a. There shall be an adequate supply of linens so that each resident shall have at least three washcloths, hand towels, and bath towels per week. (III)
b. A complete change of bed linens shall be available in the linen storage area for each bed. (III)
c. Sufficient lightweight, clean, serviceable blankets shall be available. All blankets shall be laundered as often as necessary for cleanliness and freedom from odors. (III)
d. Each bed shall be provided with clean, washable bedspreads. There shall be a supply available when changes are necessary. (III)
e. Adequate storage shall be provided for linens, pillows, and bedding. (III)

63.34(2) Supplies, equipment and storage.
a. All equipment shall be properly cleaned and sanitized before use by another resident. (III)
b. Clean and sanitary storage shall be provided for equipment and supplies. (III)
c. Locked storage should be available for potentially dangerous items such as scissors, knives, and toxic materials. (III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.35(135C) Buildings, furnishings, and equipment.

63.35(1) Buildings—general requirements.

a. All windows shall be supplied with window treatments that are kept clean and in good repair. (III)
b. Whenever glass sliding doors or transparent panels are used, they shall be marked conspicuously. (III)
c. The facility shall meet the equivalent requirements of the appropriate group occupancy of the state building code. (III)
d. The facility shall be located in an area zoned for single- or multiple-family housing or in an unincorporated area and shall be constructed in compliance with applicable local housing codes and rules adopted for this classification of license by the state fire marshal. (II, III)

63.35(2) Furnishings and equipment.

a. All furnishings and equipment shall be durable, cleanable, and appropriate to their function. (III)
b. All resident areas shall be decorated, painted, and furnished to provide a homelike atmosphere. (III)

63.35(3) Dining areas and living rooms.

a. Living rooms shall be maintained for the use of residents and their visitors and may be used for recreational activities. Living rooms shall be suitably furnished. (III)
b. Dining areas shall be furnished with dining tables and chairs appropriate to the size and function of the facility. Dining rooms and furnishings shall be kept clean and sanitary. (III)

63.35(4) Bedrooms.

a. Each resident shall be provided with a twin-sized or larger bed, substantially constructed and in good repair. Rollaway beds, metal cots, or folding beds are not acceptable. (III)
b. Each bed shall be equipped with the following: casters or glides; clean springs in good repair; a clean, comfortable, well-constructed mattress approximately five inches thick and standard in size for the bed; and clean, comfortable pillows of average bed size. (III)
c. There shall be a comfortable chair, either a rocking chair or armchair, per resident bed. The resident’s personal wishes shall be considered. (III)
d. There shall be drawer space for each resident’s clothing. In a bedroom in which more than one resident resides, drawer space shall be assigned to each resident. (III)
e. Beds and other furnishings shall not obstruct free passage to and through doorways. (III)
f. Beds shall not be placed in such a manner that the side of the bed is against the radiator or in close proximity to it unless the radiator is covered so as to protect the resident from contact with it or from excessive heat. (III)
g. There shall be a wardrobe or closet in each resident’s room. Minimum clear dimensions shall be 1 foot 10 inches deep by 1 foot 8 inches wide with full hanging space and provide a clothes rod and shelf. In a multiple bedroom, closet or wardrobe space shall be assigned each resident sufficient for the resident’s needs. (III)
h. Each room shall have sufficient accessible mirrors to serve resident’s needs. (III)
i. Useable floor space of a room shall be no less than 8 feet in any major dimension. (III)
j. Bedrooms shall have a minimum of 60 square feet of useable floor space per bed for a double room, 80 square feet of useable floor space for a single room. (III)
k. There shall be no more than two residents per room. (III)

63.35(5) Bath and toilet facilities.

a. All sinks shall have paper towel dispensers and an available supply of soap. (III)
b. Toilet paper shall be readily available to residents. (III)
c. There shall be a minimum of one toilet and bath facility for five residents. (III)

63.35(6) Heating. A centralized heating system shall be maintained in good working order and capable of maintaining a comfortable temperature for residents of the facility. Portable units or space heaters are prohibited from being used in the facility except in an emergency. (II, III)

63.35(7) Water supply.
   a. Private sources of water supply shall be tested annually and the report made available for review by the department upon request. (III)
   b. A bacterially unsafe source of water supply shall be grounds for denial, suspension, or revocation of license. (III)
   c. The department may require testing of private sources of water supply at its discretion in addition to the annual test. The facility shall supply reports of such tests as directed by the department. (III)
   d. Hot and cold running water under pressure shall be available in the facility. (II, III)
   e. Prior to construction of a new facility or new water source, private sources of water supply shall be surveyed and shall comply with the requirements of the department. (III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18; ARC 4577C, IAB 7/31/19, effective 9/4/19]

481—63.36(135C) Family and employee accommodations. If the family or employees live within the facility, separate living quarters and recreation facilities shall be required for the family or employees distinct from such areas provided for the residents. (III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.37(135C) Animals. No animals shall be allowed to reside in the facility except with written approval of the department and under controlled conditions. (II, III)

These rules are intended to implement Iowa Code chapter 135C.

[Filed 8/18/77, Notice 2/23/77—published 9/7/77, effective 10/13/77]
[Filed without Notice 10/14/77—published 11/2/77, effective 12/8/77]
[Filed 1/20/78, Notice 12/14/77—published 2/8/78, effective 3/15/78]
[Filed 7/7/78, Notice 5/31/78—published 7/26/78, effective 9/1/78]
[Filed 10/13/78, Notice 9/6/78—published 11/1/78, effective 12/7/78]
[Filed emergency 11/22/78—published 12/13/78, effective 1/3/79]
[Filed 5/20/82, Notice 12/23/81—published 6/9/82, effective 7/14/82]
[Filed 1/10/86, Notice 11/6/85—published 1/29/86, effective 3/5/86]
[Filed 5/15/86, Notice 2/26/86—published 6/4/86, effective 7/9/86]
[Filed 5/16/86, Notice 1/1/86—published 6/4/86, effective 7/9/86]
[Filed emergency 7/1/86—published 7/16/86, effective 7/1/86]
[Filed emergency 9/19/86—published 10/8/86, effective 9/19/86]
[Filed emergency after Notice 3/12/87, Notice 12/31/86—published 4/8/87, effective 3/12/87]
[Filed 3/12/87, Notice 1/25/87—published 4/8/87, effective 5/13/87]
[Filed emergency 6/25/87—published 7/15/87, effective 7/1/87]
[Filed 2/5/88, Notice 10/7/87—published 2/24/88, effective 3/30/88]
[Filed 9/30/88, Notice 8/24/88—published 10/19/88, effective 11/23/88]
[Filed 6/23/89, Notice 5/17/89—published 7/12/89, effective 8/16/89]
[Filed 7/20/89, Notice 6/14/89—published 8/9/89, effective 9/13/89]
[Filed 8/16/89, Notices 4/19/89, 7/12/89—published 9/6/89, effective 10/11/89]
[Filed 6/8/90, Notice 1/10/90—published 6/27/90, effective 8/1/90]
[Filed 7/17/90, Notice 5/2/90—published 8/8/90, effective 9/12/90]
Filed 3/14/91, Notice 9/19/90—published 4/3/91, effective 5/8/91

Filed emergency 5/10/91—published 5/29/91, effective 5/10/91

Filed 3/31/92, Notice 11/13/91—published 2/19/92, effective 3/25/92

Filed 3/12/92, Notice 12/11/91—published 4/1/92, effective 5/6/92


Filed 5/16/95, Notice 3/15/95—published 6/7/95, effective 7/12/95

Filed 11/30/95, Notice 9/13/95—published 12/20/95, effective 1/24/96

Filed 1/21/97, Notice 8/14/96—published 2/12/97, effective 3/19/97

Filed 7/11/97, Notice 4/23/97—published 7/30/97, effective 9/3/97

Filed emergency 7/25/97—published 8/13/97, effective 7/25/97

Filed emergency 11/14/97—published 12/3/97, effective 11/14/97

Filed 11/14/97, Notice 8/13/97—published 12/3/97, effective 1/7/98


Filed 7/9/98, Notice 4/22/98—published 7/29/98, effective 9/2/98

Filed 1/15/04, Notice 10/1/03—published 2/4/04, effective 3/10/04

Filed 1/15/04, Notice 12/10/03—published 2/4/04, effective 3/10/04

Filed 9/20/06, Notice 8/2/06—published 10/11/06, effective 11/15/06

Filed 7/9/08, Notice 1/30/08—published 7/30/08, effective 9/3/08

Filed ARC 0663C (Notice ARC 0513C, IAB 12/12/12), IAB 4/3/13, effective 5/8/13

Filed ARC 0765C (Notice ARC 0600C, IAB 2/6/13), IAB 5/29/13, effective 7/3/13

Filed ARC 0903C (Notice ARC 0776C, IAB 5/29/13), IAB 8/7/13, effective 9/11/13

Filed ARC 1050C (Notice ARC 0907C, IAB 8/7/13), IAB 10/2/13, effective 11/6/13

Filed ARC 1205C (Notice ARC 1082C, IAB 10/2/13), IAB 12/11/13, effective 1/15/14

Filed ARC 1204C (Notice ARC 1083C, IAB 10/2/13), IAB 12/11/13, effective 1/15/14

Filed ARC 1752C (Notice ARC 1648C, IAB 10/1/14), IAB 12/10/14, effective 1/14/15

[Editorial change: IAC Supplement 1/21/15]

Filed ARC 2643C (Notice ARC 2395C, IAB 2/3/16), IAB 8/3/16, effective 9/7/16

Filed ARC 3523C (Notice ARC 3407C, IAB 10/25/17), IAB 12/20/17, effective 1/24/18

Filed ARC 3740C (Notice ARC 3475C, IAB 12/6/17), IAB 4/11/18, effective 5/16/18

Filed ARC 4577C (Notice ARC 4467C, IAB 6/5/19), IAB 7/31/19, effective 9/4/19

0 Two or more ARCs
1 Effective date of 63.15(2) “a” and “b” delayed 70 days by the Administrative Rules Review Committee, IAB 2/26/86. Effective date of 63.15(2) “a” and “b” delayed until the expiration of 45 calendar days into the 1987 session of the General Assembly pursuant to Iowa Code section 17A.8(9), IAC 6/4/86.
2 See IAB, Inspections and Appeals Department.
3 Rule 481—63.49(135C), effective 7/1/92.
4 September 7, 2016, effective date of 57.19(3) “d,” 62.15(2) “d,” and 63.18(3) “d” [ARC 2643C] delayed 70 days by the Administrative Rules Review Committee at its meeting held August 5, 2016.
CHAPTER 154
MEDICAL CANNABIDIOL PROGRAM

641—154.1(124E) Definitions. For the purposes of these rules, the following definitions shall apply:

“Acceptance criteria” means the specified limits placed on characteristics of an item or method that are used to determine data quality.

“Accreditation” means the procedure by which an authoritative body gives formal recognition that an organization is competent to carry out specific tasks and verifies that the appropriate quality management system is in place.

“Accredited nonpublic school” means any nonpublic school accredited by the Iowa state board of education, excluding home schools.

“Action level” means the threshold value that provides the criterion for determining whether a sample passes or fails a test performed pursuant to these rules.

“Aliquot” means a portion of a sample that is used in an analysis.

“Analyte” means a chemical, compound, element, bacteria, yeast, fungus, or toxin to be identified or measured.

“Analytical batch” means a group of samples that are prepared together for the same analysis and analyzed sequentially using the same instrument calibration curve and common analytical quality control checks.

“Analytical method” means a technique used qualitatively or quantitatively to determine the composition of a sample or a microbial contamination of a sample.

“Audit” means a financial review by an independent certified public accountant that includes select scope engagement or other methods of review that analyze operational or compliance issues.

“Background investigation” means a thorough review of an entity, an owner, investors, and employees conducted by the department of public safety, including but not limited to state and national criminal history records, credit records, and internal revenue service records.

“Batch” means a set of cannabis plants that are grown, harvested, and processed together, such that they are exposed to substantially similar conditions throughout cultivation and processing.

“Batch number” means a unique numeric or alphanumeric identifier assigned to a batch of cannabis plants by a manufacturer when the batch is first planted. The batch number shall contain the manufacturer’s number and a sequence to allow for inventory and traceability.

“Biosecurity” means a set of preventative measures designed to reduce the risk of transmission of:
1. Infectious diseases in crops;
2. Quarantined pests;
3. Invasive alien species;
4. Living modified organisms.

“Bordering state” means the same as defined in Iowa Code section 331.910.

“Cannabinoid” means a chemical compound that is unique to and derived from cannabis.

“Cannabis” means seeds, plants, cuttings, or plant waste material from Cannabis sativa L. or Cannabis indica used in the manufacture of medical cannabidiol.

“CAS number” means a unique numerical identifier assigned to every chemical substance described in the open literature by Chemical Abstracts Service.

“CBD” means cannabidiol, Chemical Abstracts Service number 13956-29-1.


“CBG” means cannabigerol, Chemical Abstracts Service number 25654-31-3.


“Certificate of analysis” means the report prepared for the requester about the analytical testing performed and the results obtained by a laboratory.

“Certification” means a procedure by which a third party gives written assurance (certificate of conformity) that a product, process or service conforms to specified requirements.

“Certified” means that a laboratory demonstrates to the satisfaction of the department its ability to consistently produce valid data within the acceptance limits as specified in the department’s
requirements for certification and meets the minimum requirements of this chapter and all applicable regulatory requirements.

“Certified reference material” means a reference material prepared by a certifying body.

“Crop input” means any substance applied to or used in the cultivation and growth of a cannabis plant. “Crop input” includes, but is not limited to, pesticides, fungicides, fertilizers, and other soil or medium amendments.

“Data-quality assessment” means a scientific and statistical process that establishes whether the collected data are of the right type, quality, and quantity to support the intended use of the data.

“Date of expiration” means one year from the date of issuance of the medical cannabidiol registration card by the department of transportation.

“Date of issuance” means the date of issuance of the medical cannabidiol registration card by the department of transportation.

“Debilitating medical condition” means any of the following:
1. Cancer, if the underlying condition or treatment produces one or more of the following:
   ● Severe or chronic pain.
   ● Nausea or severe vomiting.
   ● cachexia or severe wasting.
2. Multiple sclerosis with severe and persistent muscle spasms.
3. Seizures, including those characteristic of epilepsy.
4. AIDS or HIV as defined in Iowa Code section 141A.1.
6. Amyotrophic lateral sclerosis.
7. Any terminal illness, with a probable life expectancy of under one year, if the illness or its treatment produces one or more of the following:
   ● Severe or chronic pain.
   ● Nausea or severe vomiting.
   ● cachexia or severe wasting.
8. Parkinson’s disease.
10. Any medical condition that is recommended by the medical cannabidiol board and adopted by the board of medicine by rule pursuant to Iowa Code section 124E.5 and that is listed in 653—subrule 13.15(1).

“Department” means the Iowa department of public health.

“Department of transportation” means the Iowa department of transportation.

“Director” means the director of the Iowa department of public health.

“Dispensary” means an individual or entity licensed by the department to dispense medical cannabidiol to patients and primary caregivers pursuant to Iowa Code chapter 124E and these rules.

“Dispensary” includes the employees and agents of the dispensary.

“Dispensary facility” means any secured building, space, grounds, and physical structure of a dispensary licensed by the department to dispense medical cannabidiol and where the dispensing of medical cannabidiol is authorized.

“Dispense” or “dispensing” means to supply medical cannabidiol to patients pursuant to Iowa Code chapter 124E and these rules.

“Disqualifying felony offense” means a violation under federal or state law of a felony under federal or state law, which has as an element the possession, use, or distribution of a controlled substance, as defined in 21 U.S.C. §802(6).

“Edible medical cannabidiol products” means food items containing medical cannabidiol. “Edible medical cannabidiol products” does not include pills, tinctures, oils, or other forms of medical cannabidiol that may be consumed orally or through the nasal cavity that do not contain food or food additives; provided that food or food additives used as carriers, excipients, or processing aids shall not be considered food or food additives.
“Field duplicate sample” means a sample that is taken in the identical manner and from the same batch, process lot, or lot being sampled as the primary sample. A field duplicate sample is analyzed separately from the primary sample and is used for quality control only.

“Form and quantity” means the types and amounts of medical cannabidiol allowed to be dispensed to a patient or primary caregiver as approved by the department subject to recommendation by the medical cannabidiol board and approval by the board of medicine.

“Frequency” means the number of items occurring in a given category. Frequency may be determined by analytical method or laboratory-specific requirements for the purpose of accuracy, precision of the analysis, or statistical calculation.

“Health care practitioner” means an individual licensed under Iowa Code chapter 148 to practice medicine and surgery or osteopathic medicine and surgery who is a patient’s primary care provider. “Health care practitioner” shall not include a physician assistant licensed under Iowa Code chapter 148C or an advanced registered nurse practitioner licensed pursuant to Iowa Code chapter 152 or 152E.

“Increment” or “sample increment” means a smaller sample that, together with other increments, makes up the primary sample.

“Inspection” means an on-site evaluation by the department, the department of public safety, or a department-approved independent consultant of facilities, records, personnel, equipment, methodology, and quality assurance practices for compliance with these rules.

“International Electrotechnical Commission” or “IEC” means an independent, nongovernmental membership organization that prepares and publishes international standards for all electrical, electronic, and related technologies.

“International Organization for Standardization” or “ISO” means an independent, nongovernmental membership organization and the largest developer of voluntary international standards.

“Investor” means a person making a cash investment of at least 5 percent interest in an applicant or licensed manufacturer or dispensary with the expectation of receiving financial returns.

“Laboratory” means the state hygienic laboratory at the University of Iowa or other independent medical cannabidiol testing facility accredited to Standard ISO/IEC 17025 by an ISO-approved accrediting body, with a controlled substance registration certificate from the Drug Enforcement Administration of the U.S. Department of Justice and a certificate of registration from the Iowa board of pharmacy, and approved by the department to examine, analyze, or test samples of medical cannabidiol or any substance used in the manufacture of medical cannabidiol.

“Limit of detection” or “LOD” means the lowest quantity of a substance or analyte that can be distinguished from the absence of that substance within a stated confidence limit.

“Limit of quantitation” or “LOQ” means the minimum concentration of an analyte in a specific matrix that can be reliably quantified while also meeting predefined goals for bias and imprecision.

“Lot” means a specific quantity of medical cannabidiol that is uniform and intended to meet specifications for identity, strength, purity, and composition, and that is manufactured, packaged, and labeled during a specified time period according to a single manufacturing, packaging, and labeling record.

“Lot number” means a unique numeric or alphanumeric identifier assigned to a lot by a manufacturer when medical cannabidiol is produced. The lot number shall contain the manufacturer’s number and a sequence to allow for inventory, traceability, and identification of the plant batches used in the production of a lot of medical cannabidiol.

“Manufacture” or “manufacturing” means the process of converting harvested cannabis plant material into medical cannabidiol.

“Manufacturer” means an individual or entity licensed by the department to produce medical cannabidiol and distribute it to dispensaries pursuant to Iowa Code chapter 124E and these rules. “Manufacturer” includes the employees and agents of the manufacturer.

“Manufacturing facility” means any secured building, space, grounds, and physical structure of a manufacturer for the cultivation, harvesting, packaging, processing, storage, and distribution of cannabis
or medical cannabidiol and where access is restricted to designated employees of a manufacturer and escorted visitors.

“Market withdrawal” means the voluntary removal of medical cannabidiol from dispensaries and patients by a manufacturer for minor issues that do not pose a serious health threat.

“Mass spectrometry” means an analytical technique that ionizes chemical species and sorts the ions based on their mass-to-charge ratio.

“Matrix” means the component or substrate that contains the analyte of interest.

“Matrix spike duplicate” means a duplicate sample prepared by adding a known quantity of a target analyte to a field sample matrix or other matrix that is as closely representative of the matrix under analysis as possible.

“Matrix spike sample” means a sample prepared by adding a known quantity of the target analyte to a field sample matrix or to a matrix that is as closely representative of the matrix under analysis as possible.

“Medical assistance program” means IA Health Link, Medicaid Fee-for-Service, or HAWK-I, as administered by the Iowa Medicaid Enterprise of the Iowa department of human services.

“Medical cannabidiol” means any pharmaceutical grade cannabinoid found in the plant *Cannabis sativa* L. or *Cannabis indica* or any other preparation thereof that has a tetrahydrocannabinol level of no more than 3 percent and that is delivered in a form recommended by the medical cannabidiol board, approved by the board of medicine, and designated in this chapter.

“Medical cannabidiol tracking number” means the sales identification number assigned by a dispensary to a transaction at the time of the sale of a medical cannabidiol product.

“Medical cannabidiol waste” means medical cannabidiol that is unused, unwanted, damaged, defective, expired, or contaminated and that is returned to a dispensary or manufacturer for disposal.

“Medical cannabis goods” means medical cannabidiol process lots, medical cannabidiol products, and cannabis plant material, including dried tissue.

“Method blank” means an analyte-free matrix to which all reagents are added in the same volumes or proportions as are used in sample preparation.

“Moisture content” means the percentage of water in a dry sample by weight.

“National criminal history background check” means fingerprint processing through the department of public safety and the Federal Bureau of Investigation (FBI) and review of records on file with national organizations, courts, and law enforcement agencies to the extent allowed by law.

“Non-target organism” means an organism that the test method or analytical procedure is not testing for. Non-target organisms are used in evaluating the specificity of a test method.

“Owner” means a person with a 5 percent or greater ownership interest in an applicant or licensed manufacturer or dispensary.

“Patient” means a person who is a permanent resident of the state of Iowa who suffers from a debilitating medical condition that qualifies for the use of medical cannabidiol pursuant to Iowa Code chapter 124E and these rules.

“Patient registration number” means the unique identification number issued to a patient by the department of transportation upon approval of a patient’s application by the department as described in these rules.

“Percent recovery” means the percentage of a measured concentration relative to the added (spiked) concentration in a reference material, matrix spike sample, or matrix spike duplicate.

“Permanent resident” means a natural person who physically resides in Iowa as the person’s principal and primary residence and who establishes evidence of such residency by providing the department with one of the following:

1. A valid Iowa driver’s license,
2. A valid Iowa nonoperator’s identification card,
3. A valid Iowa voter registration card,
4. A current Iowa vehicle registration certificate,
5. A utility bill,
6. A statement from a financial institution,
7. A residential lease agreement,
8. A check or pay stub from an employer,
9. A child’s school or child care enrollment documents,
10. Valid documentation establishing a filing for homestead or military tax exemption on property located in Iowa, or
11. Other valid documentation as deemed acceptable by the department to establish residency.

“Pharmaceutical grade” means medical cannabidiol that meets standards for content, contamination, and consistency set by the department as determined by testing conducted at a laboratory pursuant to Iowa Code chapter 124E and these rules.

“Plant material” means any plant of Cannabis sativa L. or Cannabis indica, or any part thereof, including flowers, leaves, trichomes, and tissue.

“Plant material waste” means plant material that is not used in the production of medical cannabidiol in a form allowable under these rules.

“Primary caregiver” means a person who is a resident of this state or a bordering state, including but not limited to a parent or legal guardian, at least 18 years of age, who has been designated by a patient’s health care practitioner as a necessary caretaker taking responsibility for managing the well-being of the patient with respect to the use of medical cannabidiol pursuant to the provisions of Iowa Code chapter 124E and these rules.

“Primary care provider” means any health care practitioner involved in the diagnosis and treatment of a patient’s debilitating medical condition.

“Primary sample” means a portion of a batch, process lot, or lot that is used for testing for identity, strength, purity, and composition.

“Process lot” means any amount of cannabinoid concentrate or extract that is uniform, produced from one or more batches, and used for testing for identity, strength, purity, and composition prior to being packaged.

“Product expiration date” means the date after which a medical cannabidiol product may not be sold by a manufacturer or a dispensary.

“Production” or “produce” means:
1. Cultivating or harvesting plant material;
2. Processing or manufacturing; or
3. Packaging of medical cannabidiol.

“Proficiency test” means an evaluation of a laboratory’s performance against preestablished criteria by means of interlaboratory comparisons of test measurements.

“Proficiency test sample” means a sample prepared by a party independent of the testing laboratory, with a concentration and identity of an analyte that is known to the independent party but is unknown to the testing laboratory and testing laboratory personnel.

“Public or private school” means any property operated by a school district, charter school, or accredited nonpublic school for purposes related to elementary, middle, or secondary schools or secondary vocation centers.

“Qualitative analysis” means identification of an analyte in a substance or mixture.

“Quality assurance” means a set of operating principles to produce data of known accuracy and precision. “Quality assurance” encompasses employee training, equipment preventative maintenance procedures, calibration procedures, and quality control testing, among other things.

“Quality control” means a set of measures implemented within an analytical procedure to ensure that the measurement system is operating in a state of statistical control in which errors have been reduced to acceptable levels.

“Quality control samples” means samples produced and used for the purpose of assuring quality control. Quality control samples include but are not limited to blank samples, spike samples, duplicate samples, and reference material samples.

“Quantitative analysis” means measurement of the quantities of chemical components present in a substance or mixture. Quantitative analysis typically uses a certified reference material, if available, to create a calibration curve.
"Reagent" means a compound or mixture added to a system to cause a chemical reaction or to test if a reaction occurs. A reagent may be used to tell whether or not a specific chemical substance is present by causing a reaction to occur with the chemical substance.

"Recall" means the return of medical cannabidiol from patients and dispensaries to a manufacturer because of the potential for serious health consequences from the use of the medical cannabidiol.

"Reference material" means a material containing a known concentration of an analyte of interest that is in solution or in a homogeneous matrix. Reference material is used to document the bias of the analytical process.

"Reference method" means a method by which the performance of an alternate method is measured or evaluated.

"Relative percent difference" or "RPD" means a comparative statistic used to calculate precision or random error. RPD is calculated using the following equation: RPD = absolute value (primary sample measurement - duplicate sample measurement) / ([primary sample measurement + duplicate sample measurement] / 2) × 100.

"Relative standard deviation" or "RSD" means the standard deviation expressed as a percentage of the mean recovery. "RSD" is the coefficient of variation multiplied by 100. If any results are less than the limit of quantitation, then the absolute value of the limit of quantitation is used in the following equation: RSD = (s / x) × 100, where s = standard deviation and x = mean recovery.

"Requester" means a person who submits a request to a licensed testing laboratory for state-mandated testing of medical cannabis goods. The requester may be a licensed manufacturer or the department.

"Residual solvents and processing chemicals" means volatile organic chemicals that are used or produced in the manufacture or production of medical cannabidiol.

"Restricted access area" means a building, room, or other contiguous area on the premises where plant material is grown, cultivated, harvested, stored, packaged, or processed for sale under control of the manufacturer, and where no person under the age of 18 is permitted.

"Sample" means a representative part or a single item from a larger whole or group.

"Sanitize" means to sterilize, disinfect, or make hygienic.

"Semiquantitative analysis" means less than quantitative precision and does not involve a full calibration. Analyte identification is based on a single-point reference or high-probability library match. The determination of amount uses the ratio of the unknown chemical analyte to that of a known analyte added to the sample before analysis. Uncertainty for semiquantitative results is higher than for quantitative results.

"Significant figures" means the number of digits used to express a measurement.

"Stability" or "stable" means that after storage of an unopened package of medical cannabidiol at a licensed manufacturing facility or dispensary facility, the contents shall not vary in concentrations of THC and CBD by more than an amount determined by the department and listed in the laboratory testing requirements and acceptance criteria document described in subrule 154.69(1).

"Standard operating procedure" means a written document that provides detailed instructions for the performance of all aspects of an analysis, operation, or action.

"State" means a state of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

"Synthetic cannabinoid" means a designed compound with structural features that allow binding to the known cannabinoid receptors present in human cells and that produce biological effects similar to those of natural cannabinoids.

"Tamper-evident" means that one or more one-time-use seals are affixed to the opening of a package, allowing a person to recognize whether or not the package has been opened.

"Target organism" means an organism that is being tested for in an analytical procedure or test method.

"Testing laboratory record" means information relating to the testing laboratory and the analyses it performs that is prepared, owned, used, or retained by the laboratory and includes electronic files and video footage.
“THC” or “delta-9 THC” means tetrahydrocannabinol, Chemical Abstracts Service number 1972-08-3.

“THCA” means tetrahydrocannabinolic acid, Chemical Abstracts Service number 23978-85-0.

“Untreatable pain” means any pain whose cause cannot be removed and, according to generally accepted medical practice, the full range of pain management modalities appropriate for the patient has been used without adequate result or with intolerable side effects.

“Validation” means the confirmation by examination and objective evidence that the particular requirements for a specific intended use are fulfilled.

“Written certification” means a document signed by a health care practitioner, with whom the patient has established a patient-provider relationship, which states that the patient has a debilitating medical condition and identifies that condition and provides any other relevant information.

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17; ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 3856C, IAB 6/6/18, effective 7/11/18; ARC 4489C, IAB 6/5/19, effective 7/10/19; see Delay note at end of chapter]

REGISTRATION CARDS

641—154.2(124E) Health care practitioner certification—duties and prohibitions.

154.2(1) Prior to a patient’s submission of an application for a medical cannabidiol registration card pursuant to this rule, a health care practitioner shall do all of the following:

a. Determine, in the health care practitioner’s medical judgment, whether the patient whom the health care practitioner has examined and treated suffers from a debilitating medical condition that qualifies for the use of medical cannabidiol as defined by this chapter, and if so determined, provide the patient with a written certification of that diagnosis by completing the health care practitioner section of the application form provided for this purpose on the department’s website (www.idph.iowa.gov).

b. Provide explanatory information to the patient as provided on the department’s website (www.idph.iowa.gov) about the therapeutic use of medical cannabidiol and the possible risks, benefits, and side effects of the proposed treatment.

154.2(2) Subsequently, the health care practitioner shall do the following:

a. Determine, on an annual basis, if the patient continues to suffer from a debilitating medical condition and, if so, issue the patient a new certification of that diagnosis.

b. Otherwise comply with all requirements in this chapter and requests from the department for more information.

154.2(3) A health care practitioner may provide, but has no duty to provide, a written certification pursuant to this rule.

154.2(4) Health care practitioner prohibitions.

a. A health care practitioner shall not accept, solicit, or offer any form of remuneration from or to any individual, including but not limited to a patient, a primary caregiver, or an employee, investor, or owner of a medical cannabidiol manufacturer or dispensary, to certify a patient’s condition, other than accepting a fee for a patient consultation to determine if the patient should be issued a certification of a qualifying debilitating medical condition.

b. A health care practitioner shall not accept, solicit, or offer any form of remuneration from or to any individual, including but not limited to a patient, a primary caregiver, or an employee, investor, or owner of a medical cannabidiol manufacturer or dispensary, to certify an individual as a primary caregiver for a patient with respect to the use of medical cannabidiol, other than accepting a fee for a consultation to determine if the individual is a necessary caretaker taking responsibility for managing the well-being of the patient with respect to the use of medical cannabidiol.

c. A health care practitioner shall not advertise certifying a qualifying debilitating medical condition as one of the health care practitioner’s services.

d. A health care practitioner shall not certify a qualifying debilitating medical condition for a patient who is the health care practitioner or a family or household member of the health care practitioner.

e. A health care practitioner shall not be designated to act as a primary caregiver for a patient for whom the health care practitioner has certified a qualifying debilitating medical condition.
641—154.3(124E) Medical cannabinoid registration card—application and issuance to patient.

154.3(1) Subject to subrule 154.3(7), the department may approve the issuance of a medical cannabinoid registration card by the department of transportation to a patient who:

a. Is at least 18 years of age.

b. Is a permanent resident of Iowa.

c. Submits a written certification to the department, provided to the patient pursuant to rule 641—154.2(124E) and signed by the patient’s health care practitioner certifying that the patient is suffering from a debilitating medical condition.

d. Submits an application to the department, on a form created by the department in consultation with the department of transportation and available at the department’s website (www.idph.iowa.gov), that contains all of the following:

(1) The patient’s full legal name, Iowa residence address, mailing address (if different from the patient’s residence address), telephone number, date of birth, and sex designation. The patient shall not provide as a mailing address an address for which a forwarding order is in place.

(2) A copy of the patient’s valid photo identification. Acceptable photo identification includes:

1. A valid Iowa driver’s license,

2. A valid Iowa nonoperator’s identification card, or

3. An alternative form of valid photo identification. A patient who possesses or is eligible for an Iowa driver’s license or an Iowa nonoperator’s identification card shall present such document as valid photo identification. A patient who is ineligible to obtain an Iowa driver’s license or an Iowa nonoperator’s identification card may apply for an exemption and request submission of an alternative form of valid photo identification. A patient who applies for an exemption is subject to verification of the patient’s identity through a process established by the department and the department of transportation to ensure the genuineness, regularity, and legality of the alternative form of valid photo identification.

(3) Full name, address, and telephone number of the patient’s health care practitioner.

(4) Full legal name, residence address, date of birth, and telephone number of each primary caregiver of the patient, if any.

(5) An attestation as to the truthfulness and accuracy of the information provided by the patient on the application.

e. Has not been convicted of a disqualifying felony offense.

f. Submits the required fee, as described in subrule 154.12(1).

154.3(2) Upon the completion, verification, and approval of the patient’s application and the receipt of the required fee, the department shall notify the department of transportation that the patient may be issued a medical cannabinoid registration card.

154.3(3) A medical cannabinoid registration card issued to a patient by the department of transportation shall contain all of the following:

a. The patient’s full legal name, Iowa residence address, date of birth, and sex designation, as shown on the patient’s Iowa driver’s license, nonoperator’s identification card, or alternative form of valid photo identification provided pursuant to paragraph 154.3(1)“d”(2)“.” If the patient’s name, Iowa residence address, date of birth, or sex designation has changed since the issuance of the patient’s Iowa driver’s license, nonoperator’s identification card, or alternative form of valid photo identification, the patient shall first update the patient’s Iowa driver’s license or nonoperator’s identification card to reflect the current information, according to the procedures set forth in 761—subrule 605.11(2), 761—subrule 605.25(4), or rule 761—630.3(321), or shall update the alternative form of valid photo identification in accordance with the process of the issuing agency.

b. The date of issuance and the date of expiration, which shall be one year from the date of issuance.

c. A distinguishing registration number that is not the patient’s social security number.
d. The patient’s signature. The signature shall be without qualification and shall contain only the patient’s usual signature without any other titles, characters, or symbols. The patient’s signature certifies, under penalty of perjury and pursuant to the laws of the state of Iowa, that the statements made and information provided in the patient’s application for a medical cannabidiol registration card are true and correct. The patient’s signature shall be captured electronically.

e. A color photograph of the patient.

f. A statement that the medical cannabidiol registration card is not valid for identification purposes.

154.3(4) Every patient 18 years of age or older must obtain a valid medical cannabidiol registration card to use medical cannabidiol in Iowa. The department may waive this requirement for a patient who is unable to obtain a card because of health, mobility, or other issues, but only when the patient:

a. Has submitted an application for a medical cannabidiol registration card;

b. Has had the application approved by the department;

c. Has been assigned a patient registration number;

d. Has designated a primary caregiver whose application has been approved and whose medical cannabidiol registration card has been issued; and

e. Complies with all provisions of Iowa Code chapter 124E.

154.3(5) An authorization to use medical cannabidiol or marijuana for medicinal purposes issued by another state, territory, or jurisdiction does not satisfy the requirements of Iowa Code chapter 124E or these rules for the issuance of a medical cannabidiol registration card.

154.3(6) A valid medical cannabidiol registration card, or its equivalent, issued under the laws of another state that allow an out-of-state patient to possess or use medical cannabidiol in the jurisdiction of issuance shall have the same force and effect as a valid medical cannabidiol registration card issued pursuant to Iowa Code chapter 124E, except that an out-of-state patient in Iowa shall not obtain medical cannabidiol from a medical cannabidiol dispensary in Iowa.

154.3(7) The department shall not approve the issuance of a medical cannabidiol registration card for a patient who is enrolled in a federally approved clinical trial for the treatment of a debilitating medical condition with medical cannabidiol.

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17; ARC 4489C, IAB 6/5/19, effective 7/10/19]

641—154.4(124E) Medical cannabidiol registration card—application and issuance to primary caregiver.

154.4(1) For a patient in a primary caregiver’s care, the department may approve the issuance of a medical cannabidiol registration card by the department of transportation to a primary caregiver who:

a. Is at least 18 years of age.

b. Submits a written certification to the department, provided to the patient pursuant to rule 641—154.2(124E) and signed by the patient’s health care practitioner certifying that the patient is suffering from a debilitating medical condition.

c. Submits an application as a primary caregiver for each patient for whom the person is the primary caregiver. The primary caregiver application must be on a form created by the department in consultation with the department of transportation and available at the department’s website (www.idph.iowa.gov) that contains all of the following:

(1) The primary caregiver’s full legal name, residence address, mailing address (if different from the primary caregiver’s residence address), telephone number, date of birth, and sex designation. The primary caregiver shall not provide as a mailing address an address for which a forwarding order is in place.

(2) The patient’s full legal name, date of birth, and parent or legal guardian’s name if the patient is under the age of 18.

(3) A copy of the primary caregiver’s valid photo identification. Acceptable photo identification includes:

1. A valid Iowa driver’s license,

2. A valid Iowa nonoperator’s identification card,
3. If the primary caregiver is not a resident of the state of Iowa, a valid state-issued driver’s license or nonoperator’s identification card issued by a state other than Iowa, or

4. An alternative form of valid photo identification. A primary caregiver who possesses or is eligible for a driver’s license or a nonoperator’s identification card shall present such document as valid photo identification. A primary caregiver who is ineligible to obtain a driver’s license or a nonoperator’s identification card may apply for an exemption and request submission of an alternative form of valid photo identification. A primary caregiver who applies for an exemption is subject to verification of the primary caregiver’s identity through a process established by the department and the department of transportation to ensure the genuineness, regularity, and legality of the alternative form of valid photo identification.

(4) Full name, address, and telephone number of the patient’s health care practitioner.

(5) An attestation as to the truthfulness and accuracy of the information provided by the primary caregiver on the application.

   d. Has not been convicted of a disqualifying felony offense.

   e. Submits the required fee, as described in subrule 154.12(2).

154.4(2) Upon the completion, verification, and approval of the primary caregiver’s application, the department shall notify the department of transportation that the primary caregiver may be issued a medical cannabidiol registration card.

154.4(3) A medical cannabidiol registration card issued to a primary caregiver by the department of transportation shall contain all of the following:

   a. The primary caregiver’s full legal name, current residence address, date of birth, and sex designation, as shown on the primary caregiver’s state-issued driver’s license, nonoperator’s identification card, or alternative form of valid photo identification provided pursuant to paragraph 154.4(1) “c’”(3)’4.” If the primary caregiver’s name, current residence address, date of birth, or sex designation has changed since issuance of the primary caregiver’s Iowa-issued driver’s license, nonoperator’s identification card, or other form of valid photo identification, the primary caregiver shall first update the primary caregiver’s Iowa-issued driver’s license or nonoperator’s identification card according to the procedures set forth in 761—subrule 605.11(2), 761—subrule 605.25(4), or rule 761—630.3(321) or update the alternative form of valid photo identification in accordance with the process of the issuing agency.

   b. The date of issuance and the date of expiration, which shall be one year from the date of issuance.

   c. A distinguishing registration number that is not the primary caregiver’s social security number.

   d. The medical cannabidiol registration number for each patient in the primary caregiver’s care. This number shall not be the primary caregiver’s or patient’s social security number. If the patient in the primary caregiver’s care is under the age of 18, the full name of the patient’s parent or legal guardian shall be printed on the primary caregiver’s registration card in lieu of the patient’s medical cannabidiol registration number.

   e. The primary caregiver’s signature. The signature shall be without qualification and shall contain only the primary caregiver’s usual signature without any other titles, characters, or symbols. The primary caregiver’s signature certifies, under penalty of perjury and pursuant to the laws of the state of Iowa, that the statements made and information provided in the primary caregiver’s application for a medical cannabidiol registration card are true and correct. The primary caregiver’s signature shall be captured electronically.

   f. A color photograph of the primary caregiver.

   g. A statement that the medical cannabidiol registration card is not valid for identification purposes.

   h. A statement distinguishing the medical cannabidiol registration cardholder as a primary caregiver.

154.4(4) A patient who is 18 years of age or older must have an approved application and a distinguishing medical cannabidiol registration number that is not the patient’s social security number prior to the issuance of a medical cannabidiol registration card to the patient’s primary caregiver.
154.4(5) An authorization to use, or to act as a primary caregiver for a patient authorized to use, cannabidiol or marijuana for medicinal purposes issued by another state, territory, or jurisdiction does not satisfy the requirements of Iowa Code chapter 124E or these rules for the issuance of a medical cannabidiol registration card.
[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.5(124E) Tamperproofing. The department of transportation shall issue a medical cannabidiol registration card by a method or process which prevents as nearly as possible the alteration, reproduction, or superimposition of a photograph on the cannabidiol registration card without ready detection.
[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.6(124E) Denial and cancellation. The department may deny an application for a medical cannabidiol registration card, or may cancel or direct the department of transportation to cancel a medical cannabidiol registration card, for any of the following reasons:
1. Information contained in the application is illegible, incomplete, falsified, misleading, deceptive, or untrue.
2. The department or the department of transportation is unable to verify the identity of the applicant from the photo identification or other documentation presented pursuant to paragraph 154.3(1)”d”(2)”3” or 154.4(1)”c”(3)”4.”
3. The applicant violates or fails to satisfy any of the provisions of Iowa Code chapter 124E or these rules.
4. A patient, the patient’s legal guardian, or other person with durable power of attorney requests in writing that the department cancel the patient’s medical cannabidiol registration card. The department shall notify a primary caregiver in writing when the registration card of the primary caregiver’s patient has been canceled.
5. A primary caregiver requests in writing that the department cancel the primary caregiver’s medical cannabidiol registration card. The department shall notify a patient in writing when the registration card of the patient’s primary caregiver has been canceled.
6. The department becomes aware of the death of a patient or primary caregiver.
[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17; ARC 4489C, IAB 6/5/19, effective 7/10/19]

641—154.7(124E) Appeal. If the department denies an application for or cancels a medical cannabidiol registration card, the department shall inform the applicant or cardholder of the denial or cancellation and state the reasons for the denial or cancellation in writing. An applicant or cardholder may appeal the denial or cancellation of a medical cannabidiol registration card by submitting a request for appeal to the department by certified mail, return receipt requested, within 20 days of receipt of the notice of denial or cancellation. The department’s address is Iowa Department of Public Health, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319-0075. Upon receipt of a request for appeal, the department shall forward the request within five working days to the department of inspections and appeals. A contested case hearing shall be conducted in accordance with 641—Chapter 173.
[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.8(124E) Duplicate card.
154.8(1) Lost, stolen, or destroyed card. To replace a medical cannabidiol registration card that is lost, stolen, or destroyed, a cardholder shall present to the department of transportation the cardholder’s valid state-issued driver’s license, nonoperator’s identification card, or alternative form of valid photo identification provided pursuant to paragraph 154.3(1)”d”(2)”3” or 154.4(1)”c”(3)”4.”

154.8(2) Change in card information and voluntary replacement.
a. To replace a medical cannabidiol registration card that is damaged, the cardholder shall surrender to the department of transportation the card to be replaced and present the cardholder’s valid state-issued driver’s license, nonoperator’s identification card, or alternative form of valid photo identification provided pursuant to paragraph 154.3(1)”d”(2)”3” or 154.4(1)”c”(3)”4.”
A patient or primary caregiver to whom a medical cannabidiol registration card is issued shall notify the department of a change in current residence address, name, or sex designation listed on the card, within ten calendar days of the change. To replace a medical cannabidiol registration card to change the current residence address, name, or sex designation listed on the card, the cardholder shall surrender to the department of transportation the card to be replaced and present a valid state-issued driver’s license, nonoperator’s identification card, or alternative form of valid photo identification provided pursuant to paragraph 154.3(1)“d”(2)“3” or 154.4(1)“c”(3)“4” that has been updated according to the procedures established by the state or agency of issuance to reflect the requested residence address, name, or sex designation.

To replace a medical cannabidiol registration card held by a primary caregiver to change, add, or remove a patient’s medical cannabidiol registration number or the name of a patient’s parent or legal guardian listed on the primary caregiver’s card, the primary caregiver shall submit a new application to the department pursuant to rule 641—154.4(124E). A medical cannabidiol registration card issued pursuant to this paragraph shall not be considered a duplicate card.

**Expiration date.** A duplicate medical cannabidiol registration card shall have the same expiration date as the medical cannabidiol registration card being replaced, changed, or amended.

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17]

**Renewal.** A medical cannabidiol registration card shall be valid for one year from the date of issuance unless canceled pursuant to rule 641—154.6(124E).

**A cardholder seeking renewal of a medical cannabidiol registration card shall submit a renewal application and fee to the department at least 60 days prior to the date of expiration.**

- A patient applying for renewal of a medical cannabidiol registration card shall submit a renewal application and fee to the department on a form approved by the department.
- A primary caregiver applying for a renewal of a medical cannabidiol registration card shall submit a renewal application and fee to the department on a form approved by the department.

**A cardholder who fails to renew the medical cannabidiol registration card may not lawfully possess medical cannabidiol pursuant to this chapter.**

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17]

**Confidentiality.** The department shall maintain a confidential file of the names of each patient to or for whom the department approves the issuance of a medical cannabidiol registration card and the name of each primary caregiver to whom the department issues a medical cannabidiol registration card under Iowa Code section 124E.4.

**Personally identifiable information of patients and primary caregivers shall be maintained as confidential and is not accessible to the public.** The department and the department of transportation shall release aggregate and statistical information regarding the medical cannabidiol act registration card program in a manner which prevents the identification of any patient or primary caregiver.

**Personally identifiable information of patients and primary caregivers may be disclosed under the following limited circumstances:**

- To authorized employees or agents of the department and the department of transportation as necessary to perform the duties of the department and the department of transportation pursuant to Iowa Code chapter 124E.
- To authorized employees of state or local law enforcement agencies located in Iowa, solely for the purpose of verifying that a person is lawfully in possession of a medical cannabidiol registration card issued pursuant to Iowa Code chapter 124E.
- To a patient, primary caregiver, or health care practitioner, upon written authorization of the patient or primary caregiver.

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17]

**Agreement with department of transportation.** The department may enter into a chapter 28E agreement with the department of transportation to facilitate the issuance of medical cannabidiol registration cards. The agreement may include provisions which govern the issuance,
denial, and cancellation of medical cannabidiol registration cards, the sharing of information between the department and the department of transportation, and reimbursement for costs incurred by the department of transportation for issuing the card.

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.12(124E) Fees. All fees are nonrefundable.

154.12(1) Patient medical cannabidiol registration card fee.

a. Each application fee is $100 unless the patient qualifies for a reduced fee as described in paragraph 154.12(1)“b.”

b. Each reduced application fee is $25 if the patient attests to receiving social security disability benefits, supplemental security income payments, or is enrolled in the medical assistance program as defined in rule 641—154.1(124E).

c. Each renewal fee is the same as the initial card application fee.

154.12(2) Primary caregiver medical cannabidiol registration card fee.

a. Each application fee is $25.

b. Each renewal fee is $25.

[ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.13(124E) Use of medical cannabidiol—smoking prohibited. A patient shall not consume medical cannabidiol possessed or used pursuant to Iowa Code chapter 124E by smoking medical cannabidiol.

[ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.14(124E) Form and quantity of medical cannabidiol. The form and quantity of medical cannabidiol authorized in this rule may be modified pursuant to recommendations by the medical cannabidiol board, subsequent approval of the recommendations by the board of medicine and adoption of the recommendations by the department by rule.

154.14(1) Quantity. A 90-day supply is the maximum amount of each product that shall be dispensed by a dispensary at one time.

154.14(2) Form.

a. A manufacturer may only manufacture medical cannabidiol in the following forms:

(1) Oral forms, including but not limited to:

1. Tablet.
2. Capsule.
3. Liquid.
4. Tincture.
5. Sublingual.

(2) Topical forms, including but not limited to:

1. Gel.
2. Ointment, cream or lotion.
3. Transdermal patch.

(3) Inhaled forms, limited to:

1. Nebulizable.
2. Vaporizable.

(4) Rectal/vaginal forms, including but not limited to suppository.

b. A manufacturer may not produce medical cannabidiol in any form that may be smoked.

c. A manufacturer may not produce medical cannabidiol in an edible form as defined in rule 641—154.1(124E).

[ARC 3150C, IAB 7/5/17, effective 6/13/17; ARC 3836C, IAB 6/6/18, effective 7/11/18; ARC 4399C, IAB 4/10/19, effective 5/15/19]

641—154.15 Reserved.
MANUFACTURING

641—154.16(124E) Duties of the department.

154.16(1) Interagency agreements. The department may enter into any interagency agreements with other state agencies for technical services or other assistance related to the regulation or inspection of manufacturers.

154.16(2) Notice to law enforcement. The department shall notify local law enforcement agencies and the department of public safety of the locations of manufacturers. If the department determines there is a threat to public safety, the department shall notify local law enforcement agencies and the department of public safety of any conditions that pose a threat to public safety, including but not limited to:

a. Loss or theft of medical cannabidiol or plant material;

b. Diversion or potential diversion of medical cannabidiol or plant material;

c. Unauthorized access to the secure sales and inventory tracking system or other patient and caregiver information system or file; or

d. Other violations of law.

154.16(3) Inspection of manufacturers. The department or its agents shall conduct regular inspections of manufacturers and manufacturing facilities as described in rule 641—154.28(124E).

154.16(4) Establishment and maintenance of a secure sales and inventory tracking system. The department shall establish and maintain a secure, electronic system that is available 24 hours a day, seven days a week to track:

a. Inventory of plant material, medical cannabidiol, and waste material;

b. Transport of plant material, waste material, and laboratory samples;

c. Application and use of crop inputs and other solvents and chemicals;

d. Sales of medical cannabidiol to dispensaries;

e. Sales of medical cannabidiol from dispensaries to patients and primary caregivers.

154.16(5) Licensure and licensure renewal of manufacturers. The department shall issue a request for proposals to select and license by December 1, 2017, up to two manufacturers to manufacture and to possess, cultivate, harvest, transport, package, process, and supply medical cannabidiol within the state consistent with the provisions of Iowa Code chapter 124E and these rules.

a. To be eligible for licensure, an applicant manufacturer shall provide information on forms and in a manner required by the department of public safety for the completion of a background investigation. In addition, the applicant manufacturer shall submit to the department of public safety necessary funds to satisfy the full reimbursement of costs associated with completing the background investigations. If an applicant manufacturer is not found suitable for licensure as a result of the background investigation, a license shall not be issued by the department.

b. As a condition for licensure, an applicant manufacturer shall agree to begin supplying medical cannabidiol to licensed medical cannabidiol dispensaries in Iowa no later than December 1, 2018.

c. The initial license to manufacture medical cannabidiol shall be valid from December 1, 2017, through November 30, 2018. The license shall be renewed annually unless a manufacturer relinquishes the license, there is a change in state law prohibiting the department from renewing the license, or the license is revoked pursuant to Iowa Code chapter 124E or these rules.

d. A license to manufacture issued by the department pursuant to these rules is not assignable or transferable.

e. The department shall consider the following factors in determining whether to select and license a medical cannabidiol manufacturer:

(1) The technical expertise of an applicant manufacturer regarding medical cannabidiol;

(2) The qualifications of an applicant manufacturer’s employees;

(3) The long-term financial stability of an applicant manufacturer;

(4) The ability to provide appropriate security measures on the premises of an applicant manufacturer;

(5) Whether an applicant manufacturer has demonstrated an ability to meet certain medical cannabidiol production needs for medical use regarding the range of recommended dosages for each
debilitating medical condition, the range of chemical compositions of any plant of the genus cannabis that will likely be medically beneficial for each of the debilitating medical conditions, and the form or forms of medical cannabis that may be appropriate for the approved debilitating medical conditions;

(6) An applicant manufacturer’s projection of and ongoing assessment of wholesale product costs.

f. Pursuant to Iowa Code section 124E.61 “b,” information submitted during the application process shall be confidential until the licensure process is completed unless otherwise protected from disclosure under state or federal law.

g. A licensed manufacturer shall submit an application to renew its license with the department at least six months before the license expires. The application shall be submitted on a form created by the department.

h. The department shall notify a manufacturer of the decision to approve or deny the manufacturer’s license by August 1 of the year in which the renewal application is submitted.

154.16(6) Collection of fees from manufacturers. Except as provided in this rule, all fees are nonrefundable, shall be retained by the department, and shall be considered repayment receipts as defined in Iowa Code section 8.2.

a. Fees to the department.

(1) Each application for licensure as a manufacturer shall include a nonrefundable application fee of $7,500.

(2) Licensed manufacturers shall pay an annual fee to the department to cover costs associated with regulating and inspecting manufacturers and for other expenses necessary for the administration of the medical cannabis program. The department shall assess the fee with the notice of approval of license renewal each year by August 1, payable by the manufacturer to the department no later than December 1.

b. Fees to the department of public safety.

(1) An applicant manufacturer shall be responsible to reimburse the department of public safety the full cost of conducting background investigations related to an application for licensure and operation as a licensed manufacturer. The department of public safety shall retain the right to bill a manufacturer for additional background investigations, as needed.

(2) Each manufacturer submitting an application for licensure shall, at the time of application, submit to the department of public safety a deposit of $10,000 for each business owner subject to a background investigation and a national criminal history background check. Background investigation costs shall be deducted from the funds deposited. If the background investigation fees exceed the funds deposited, the applicant shall submit additional funds as required by the department of public safety. If the background investigation fees are less than the funds deposited, the department of public safety may refund or retain the fees as mutually agreed with the manufacturer.

(3) A licensed manufacturer shall pay a deposit of $200 per employee to the department of public safety for a background investigation and a national criminal history background check on any person being considered for hire as an employee of the manufacturer. Background investigation costs shall be deducted from the funds deposited. If the background investigation fees exceed the funds deposited, the manufacturer shall submit additional funds as required by the department of public safety. If the background investigation fees are less than the funds deposited, the department of public safety may refund or retain the fees as mutually agreed with the manufacturer. The department shall retain the right to preclude a potential employee from hire based upon the results of the background investigation and national criminal history background check.

154.16(7) Recall of medical cannabis products. The department may require a manufacturer to recall medical cannabis from dispensaries when there is potential for serious health consequences from use of the products as determined by the department. Situations that may require a recall include but are not limited to:

a. After consultation with the department’s medical director, it is determined that the distribution, sale, or use of the medical cannabis creates or poses an immediate and serious threat to human life or health; and
b. Other procedures available to the department to prevent or remedy a situation would result in an unreasonable delay that may place the health of patients at risk.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4489C, IAB 6/5/19, effective 7/10/19; see Delay note at end of chapter]

641—154.17(124E) Manufacturer operations.

154.17(1) Operating documents.

a. A manufacturer shall maintain operating documents that accurately reflect the manufacturer’s standard operating procedures. Unless otherwise noted, a manufacturer shall make the operating documents available to the department upon request through secure electronic mail, an electronic file-sharing service, or other secure means.

b. The operating documents of a manufacturer shall include all of the following:

(1) Procedures for the oversight of the manufacturer, including descriptions of operational and management practices regarding:

1. The forms and quantities of medical cannabidiol products that are produced at the manufacturing facility;
2. The methods of planting, harvesting, drying, and storing cannabis. A manufacturer may make operating documents for these procedures available on site only;
3. The estimated types and amounts of all crop inputs used in the production of medical cannabidiol;
4. The estimated types and amounts of medical cannabidiol waste and plant material waste to be generated;
5. The disposal methods for all waste materials;
6. Employee training methods for the specific phases of production. A manufacturer may make operating documents for these procedures available on site only;
7. Biosafety measures and standard operating procedures used in the production and manufacturing of medical cannabidiol. A manufacturer may make operating documents for these procedures available on site only;
8. Strategies for identifying and reconciling discrepancies in inventory of plant material or medical cannabidiol;
9. Sampling strategy and quality testing for labeling purposes. A manufacturer may make operating documents for these procedures available on site only;
10. Medical cannabidiol packaging and labeling procedures;
11. Procedures for recall and market withdrawal of medical cannabidiol;
12. Plans for responding to a security breach at a manufacturing facility or while medical cannabidiol is in transit to a dispensary. A manufacturer may make operating documents for these procedures available on site only;
13. A business continuity plan. A manufacturer may make this operating document available on site only;
14. Records relating to all transport activities; and
15. Other information requested by the department.

(2) Procedures to ensure accurate record keeping.

(3) Procedures for the implementation of appropriate security measures to deter and prevent the theft of medical cannabidiol and unauthorized entrance into areas containing medical cannabidiol. A manufacturer may make operating documents for these procedures available on site only.

c. Operating documents may be trade secrets if designated as such by a manufacturer and shall be considered confidential records pursuant to Iowa Code section 22.7(3).

154.17(2) Prohibited activities. A manufacturer shall not:

a. Own or operate a medical cannabidiol manufacturing facility unless the manufacturer is licensed by the department pursuant to Iowa Code chapter 124E and these rules;

b. Produce or manufacture medical cannabidiol in any location except in those areas approved by the department;
c. Sell, deliver, transport, or distribute medical cannabidiol from any location except its manufacturing facility or a dispensary facility;

d. Produce or manufacture medical cannabidiol in Iowa for sales or distribution outside of Iowa;

e. Sell or distribute medical cannabidiol to any person or business other than a dispensary;

f. Refuse to sell, deliver, transport, or distribute medical cannabidiol in any form or quantity produced by the manufacturer to a dispensary, unless deemed appropriate in the manufacturer’s reasonable business judgment and approved by the department in writing;

g. Transport or deliver medical cannabidiol to any location except as allowed in subrule 154.22(1);

h. Sell medical cannabidiol that is not packaged and labeled in accordance with rule 641—154.21(124E);

i. Sell medical cannabidiol in any form or quantity other than a form or quantity approved by the department, subject to recommendation by the medical cannabidiol board and approval by the board of medicine;

j. Permit any person to consume medical cannabidiol on the property of the manufacturer;

k. Employ a person who is under 18 years of age or who has been convicted of a disqualifying felony offense;

l. Manufacture edible medical cannabidiol products.

154.17(3) Criminal background investigations.

a. A manufacturer shall not have been convicted of a disqualifying felony offense and shall be subject to a background investigation conducted by the department of public safety, including but not limited to a national criminal history record check.

b. An employee of a manufacturer shall not have been convicted of a disqualifying felony offense and shall be subject to a background investigation conducted by the department of public safety, including but not limited to a national criminal history background check.

c. An applicant or licensed manufacturer shall respond within 30 days to a request from the department or the department of public safety for more information to complete a background investigation and national criminal history background check on an owner, investor, or employee.

154.17(4) Relationship to health care practitioners. A manufacturer shall not share office space with, refer patients to, or have any financial relationship with a health care practitioner.

[ARC 3696C, IAB 1/31/18, effective 3/7/18; ARC 3836C, IAB 6/6/18, effective 7/11/18; ARC 4489C, IAB 6/5/19, effective 7/10/19]

641—154.18(124E) Security requirements. The department may request assistance from the department of public safety in ensuring manufacturers meet the security requirements in this rule.

154.18(1) Visitor logs. Visitors to the manufacturing facility shall sign visitor manifests with name, date, and times of entry and exit, and shall wear badges that are visible at all times and that identify them as visitors.

154.18(2) Restricted access. A manufacturer shall use a controlled access system and written manifests to limit entrance to all restricted access areas of its manufacturing facility and shall retain a record of all persons who entered the restricted access areas.

a. The controlled access system shall do all of the following:

1. Limit access to authorized individuals;

2. Maintain a log of individuals with approved access, including dates of approvals and revocations;

3. Track times of personnel entry to and exit from the facility;

4. Store data for retrieval for a minimum of one year; and

5. Limit access to authorized individuals in the event of a power failure.

b. Separate written manifests of visitors to restricted access areas shall be kept and stored for a minimum of one year if the controlled access system does not include electronic records of visitors to the restricted access areas.

C. A manufacturer shall promptly, but no later than five business days after receipt of request, submit stored controlled access system data to the department.
d. Restricted access areas shall be identified with signs that state: “Do Not Enter – Restricted Access Area – Access Limited to Authorized Personnel Only.”

154.18(3) Perimeter intrusion detection system.

a. Computer-controlled video surveillance system. A manufacturer shall operate and maintain in good working order a computer-controlled, closed-circuit television surveillance system on its premises that operates 24 hours per day, seven days a week, and visually records:

(1) All phases of medical cannabidiol production;
(2) All areas that might contain plant material and medical cannabidiol, including all safes and vaults;
(3) All points of entry and exit;
(4) The entrance to the video surveillance control room; and
(5) Parking areas, which shall have appropriate lighting for the normal conditions of the area under surveillance.

b. Camera specifications. Cameras shall:

(1) Capture clear and certain identification of any person entering or exiting a manufacturing facility or its parking areas to the extent identification is technologically feasible with generally accepted commercial security cameras;
(2) Have the ability to produce a clear, color still photograph live or from a recording;
(3) Have on all recordings an embedded date-and-time stamp that is synchronized to the recording and does not obscure the picture; and
(4) Continue to operate during a power outage.

c. Video recording specifications.

(1) A video recording shall export still images in an industry standard image format, such as .jpg, .bmp, or .gif.
(2) Exported video shall be archived in a format that ensures authentication and guarantees that the recorded image has not been altered.
(3) Exported video shall also be saved in an industry standard file format that can be played on a standard computer operating system.
(4) All recordings shall be erased or destroyed at the end of the retention period and prior to disposal of any storage medium.

d. Additional requirements. A manufacturer shall maintain all security system equipment and recordings in a secure location to prevent theft, loss, destruction, corruption, and alterations.

e. Retention. A manufacturer shall ensure that recordings from all video cameras are:

(1) Available for viewing by the department upon request;
(2) Retained for at least 60 days;
(3) Maintained free of alteration or corruption; and
(4) Retained longer, as needed, if a manufacturer is given actual notice of a pending criminal, civil, or administrative investigation, or other legal proceeding for which the recording may contain relevant information.

f. Required signage. A manufacturer shall post a sign in capital letters in a conspicuous location at every entrance to the manufacturing facility that reads, “THESE PREMISES ARE UNDER CONSTANT VIDEO SURVEILLANCE.”

154.18(4) Security alarm system requirements.

a. A manufacturer shall install and maintain a professionally monitored security alarm system that provides intrusion and fire detection of all:

(1) Facility entrances and exits;
(2) Rooms with exterior windows;
(3) Rooms with exterior walls;
(4) Roof hatches;
(5) Skylights; and
(6) Storage rooms.
b. For the purposes of this subrule, a security alarm system means a device or series of devices that summons law enforcement personnel during, or as a result of, an alarm condition. Devices may include:
   (1) Hardwired systems and systems interconnected with a radio frequency method such as cellular or private radio signals that emit or transmit a remote or local audio, visual, or electronic signal;
   (2) Motion detectors;
   (3) Pressure switches;
   (4) A duress alarm;
   (5) A panic alarm;
   (6) A holdup alarm;
   (7) An automatic voice dialer; and
   (8) A failure notification system that provides an audio, text, or visual notification of any failure in the surveillance system.

   c. A manufacturer’s security alarm system and all devices shall continue to operate during a power outage.

   d. A manufacturer’s security alarm system shall be inspected and all devices tested annually by a qualified alarm vendor. A manufacturer shall provide documentation of the annual inspection and device testing to the department upon request.

154.18(5) Personnel identification system. A manufacturer shall use a personnel identification system that controls and monitors individual employee access to restricted access areas within the manufacturing facility and that meets the requirements of this subrule and subrule 154.18(1).

   a. Requirement for employee identification card. An employee identification card shall contain:
      (1) The name of the employee;
      (2) The date of issuance and expiration;
      (3) An alphanumeric identification number that is unique to the employee; and
      (4) A photographic image of the employee.

   b. A manufacturer’s employee shall keep the identification card visible at all times when the employee is in a manufacturing facility, a dispensary, or a vehicle transporting medical cannabidiol.

   c. Upon termination or resignation of an employee, a manufacturer shall immediately:
      (1) Revoke the employee’s access to the manufacturing facility; and
      (2) Obtain and destroy the employee’s identification card, if possible.

[ARC 3606C; IAB 1/31/18, effective 3/7/18]

641—154.19(124E) Location. All of a manufacturer’s manufacturing, cultivating, harvesting, packaging, processing, and storage of medical cannabidiol shall take place in one secured manufacturing facility location at a physical address provided to the department during the licensure and application processes.

154.19(1) Proximity to dispensary. A manufacturer shall not operate a manufacturing facility at the same physical location as a medical cannabidiol dispensary.

154.19(2) Proximity to school. A manufacturer shall not operate a manufacturing facility in any location, whether for manufacturing, possessing, cultivating, harvesting, transporting, packaging, processing, storing, or supplying, within 1,000 feet of a public or private school existing before the date of the manufacturer’s licensure by the department.

[ARC 3606C; IAB 1/31/18, effective 3/7/18]

641—154.20(124E) Advertising and marketing.

154.20(1) Permitted marketing and advertising activities.

   a. A manufacturer may:
      (1) Display the manufacturer’s business name and logo on medical cannabidiol labels, signs, website, and informational material provided to patients. The name or logo shall not include:
      1. Images of cannabis or cannabis-use paraphernalia;
      2. Colloquial references to cannabis;
      3. Names of cannabis plant strains or varieties;
      4. Unsubstantiated medical claims; or
5. Medical symbols that bear a reasonable resemblance to established medical associations. Examples of established medical organizations include the American Medical Association or American Academy of Pediatrics. The use of medical symbols is subject to approval by the department;
   (2) Display signs on the manufacturing facility; and
   (3) Maintain a business website that contains the following information:
      1. The manufacturer’s name and contact information;
      2. The medical cannabidiol forms and quantities manufactured in Iowa; and
      3. Other information as approved by the department.
   b. The business website shall not include any false, misleading, or unsubstantiated statements regarding health or physical benefits to the patient.
   c. The department reserves the right to review a manufacturer’s marketing and advertising materials and to require a manufacturer to make changes to the content. The department has 30 calendar days following submission to approve or deny marketing and advertising materials of a manufacturer.
   154.20(2) Other marketing and advertising activities. A manufacturer shall request and receive the department’s written approval before beginning marketing or advertising activities that are not specified in subrule 154.20(1). The department has 30 calendar days to approve, deny, or request additional information regarding marketing and advertising activity requests from a manufacturer. In the event the department fails to respond to a manufacturer within 30 days with an approval, denial, or request for additional information, the manufacturer’s marketing and advertising activity requests shall be deemed approved.
   154.20(3) Inconspicuous display. A manufacturer shall arrange displays of medical cannabidiol, interior signs, and other exhibits to reasonably prevent public viewing from outside the manufacturing facility.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.21(124E) Packaging and labeling.

154.21(1) Medical cannabidiol packaging. A manufacturer shall package all medical cannabidiol intended for distribution according to the following standards:
   a. The manufacturer shall properly package medical cannabidiol in compliance with the United States Poison Prevention Packing Act regarding child-resistant packaging and exemptions for packaging for elderly patients.
   b. The manufacturer shall label packaged medical cannabidiol as described in subrule 154.21(3).
   c. The manufacturer shall use medical containers that are:
      (1) Of sufficient size to accommodate a separate dispensary label containing the information described in rule 641—154.46(124E);
      (2) Designed to maximize the shelf life of the contained medical cannabidiol;
      (3) Tamper-evident; and
      (4) Child-resistant.
   d. Medical cannabidiol packaging shall not bear a reasonable resemblance to commonly available nonmedical commercial products.
   e. The manufacturer shall package medical cannabidiol in a manner that minimizes the package’s appeal to children.
   f. The manufacturer shall not depict images other than the manufacturer’s business name or logo on the packaging.
   154.21(2) Trade names. A manufacturer’s medical cannabidiol trade names shall comply with the following:
      a. Names shall be limited to those that clearly reflect the form’s medical cannabidiol nature;
      b. Any name that is identical to, or similar to, the name of an existing nonmedical cannabidiol product is prohibited;
      c. Any name that is identical to, or similar to, the name of an unlawful product or substance is prohibited; and
d. Any name that contains language that suggests using medical cannabidiol for recreational purposes or for a condition other than a qualifying debilitating medical condition is prohibited.

154.21(3) Package labeling.
   a. A manufacturer shall ensure that all medical cannabidiol packaging is labeled with the following information:
      (1) The name of the manufacturer;
      (2) The medical cannabidiol’s primary active ingredients, including concentrations of tetrahydrocannabinol, tetrahydrocannabinolic acid, cannabidiol, and cannabidiolic acid. Concentrations of tetrahydrocannabinolic acid and cannabidiolic acid may be omitted if the manufacturer uses chemical decarboxylation or other means to substantially remove the acids from the product prior to testing;
      (3) All ingredients of the product shown with common or usual names, including any colors, artificial flavors, and preservatives, listed in descending order by predominance of weight;
      (4) Instructions for storage, including light and temperature requirements, if any;
      (5) Product expiration date;
      (6) The date of manufacture and lot number;
      (7) A notice with the statement, including capitalization: “This product has not been analyzed or approved by the United States Food and Drug Administration. There is limited information on the side effects of using this product, and there may be associated health risks and medication interactions. This product is not recommended for use by pregnant or breastfeeding women. KEEP THIS PRODUCT OUT OF REACH OF CHILDREN.”;
      (8) The universal warning symbol provided by the department; and
      (9) A notice with the statement: “This medical cannabidiol is for therapeutic use only. Use of this product by a person other than the patient listed on the label is unlawful and may result in the cancellation of the patient’s medical cannabidiol registration card. Return unused medical cannabidiol to a dispensary for disposal.”
   b. Labeling text shall not include any false or misleading statements.
   c. A package may contain multiple labels if the information required by this rule is not obstructed.
   d. A manufacturer shall ensure that directions for use of the product, including recommended and maximum amount by age and weight, if applicable, are included with the product.

[ARC 3606C; IAB 1/31/18, effective 3/7/18; ARC 3836C, IAB 6/6/18, effective 7/11/18; ARC 4489C, IAB 6/5/19, effective 7/10/19]

641—154.22(124E) Transportation of medical cannabidiol and plant material.

154.22(1) Transport of medical cannabidiol. A manufacturer is authorized to transport medical cannabidiol to and from:
   a. Dispensaries;
   b. A laboratory for testing;
   c. A waste facility for disposal;
   d. Other sites only with departmental approval.

154.22(2) Transport of plant material. A manufacturer is authorized to transport cannabis plant material from its manufacturing facility to:
   a. A waste disposal site;
   b. Other sites only with departmental approval.

154.22(3) Chain-of-custody tracking system.
   a. A manufacturer shall use the secure sales and inventory tracking system, if available, or a department-approved manifest system to track shipping of medical cannabidiol. The system shall include a chain of custody that records:
      (1) The name and address of the destination;
      (2) The weight and description of each individual package that is part of the shipment, and the total number of individual packages;
      (3) The date and time the medical cannabidiol shipment is placed into the transport vehicle;
      (4) The date and time the shipment is accepted at the delivery destination;
(5) The person’s identity, and the circumstances, duration, and disposition of any other person who had custody or control of the shipment; and

(6) Any handling or storage instructions.

b. Before transporting medical cannabidiol, a manufacturer shall:
   (1) Record in the secure sales and inventory tracking system or on the manifest information about the material to be transported; and
   (2) Notify the dispensary, laboratory, or waste facility, as applicable, of the expected arrival time and transmit a copy of the manifest to the dispensary, laboratory, or waste facility, if applicable.

c. Each transport shall be approved electronically or in writing by:
   (1) An authorized manufacturer employee when the transport vehicle is departing the manufacturing facility; and
   (2) An authorized employee of the receiving dispensary, laboratory, or waste facility.

d. An authorized employee at the dispensary, laboratory, or waste facility receiving medical cannabidiol shall:
   (1) Verify and document the type and quantity of the transported medical cannabidiol against the information in the secure sales and inventory tracking system or written manifest;
   (2) Approve the transport electronically or return a signed copy of the manifest to the manufacturing facility; and
   (3) Record the medical cannabidiol that is received as inventory in the secure sales and inventory tracking system, if applicable. If a manifest system is being used, the dispensary, laboratory, or waste facility shall also maintain a signed copy of manifest, and shall maintain records of the inventory received consistent with these rules.

e. A manufacturer shall maintain all manifests for at least five years and make them available upon request of the department.

154.22(4) Vehicle requirements for transport.

a. A manufacturer shall ensure that all medical cannabidiol transported on public roadways is:
   (1) Packaged in tamper-evident, bulk containers;
   (2) Transported so it is not visible or recognizable from outside the vehicle; and
   (3) Transported in a vehicle that does not bear any markings to indicate that the vehicle contains medical cannabidiol or bears the name or logo of the manufacturer.

b. When the motor vehicle contains medical cannabidiol, manufacturer employees who are transporting the medical cannabidiol on public roadways shall:
   (1) Travel directly to a dispensary or other department-approved locations; and
   (2) Document refueling and all other stops in transit, including:
      1. The reason for the stop;
      2. The duration of the stop; and
      3. The location of the stop.

c. If the vehicle must be stopped due to an emergency situation, the employee shall notify 911 and complete an incident report on a form approved by the department.

d. Under no circumstance shall any person other than a designated manufacturer employee have actual physical control of the motor vehicle that is transporting the medical cannabidiol.

e. A manufacturer shall staff all motor vehicles with a minimum of two employees when transporting medical cannabidiol between a manufacturing facility and a dispensary. At least one employee shall remain with the motor vehicle at all times that the motor vehicle contains medical cannabidiol. A single employee may transport medical cannabidiol to the laboratory.

f. Each employee in a transport motor vehicle shall have telephone or other communication access with the manufacturer’s personnel and have the ability to contact law enforcement via telephone or other method at all times that the motor vehicle contains medical cannabidiol.

g. An employee shall carry the employee’s identification card at all times when transporting or delivering medical cannabidiol and, upon request, produce the identification card to the department or to a law enforcement officer acting in the course of official duties.
h. A manufacturer shall not leave a vehicle that is transporting medical cannabidiol unattended overnight.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.23(124E) Disposal of medical cannabidiol and plant material.

154.23(1) Return of medical cannabidiol from dispensaries and laboratory. A manufacturer shall collect at no charge medical cannabidiol waste from dispensaries and from the laboratory that has tested samples submitted by the manufacturer. A manufacturer shall:

a. Collect medical cannabidiol waste from each dispensary on a schedule mutually agreed upon by the manufacturer and dispensary;

b. Collect medical cannabidiol waste from a laboratory on a schedule mutually agreed upon by the manufacturer and laboratory;

c. Dispose of medical cannabidiol waste as provided in subrule 154.23(2); and

d. Maintain a written record of disposal that includes:

(1) The tracking number assigned at the time of the dispensing, if available, or the name of the patient, if the tracking number is unavailable, when the medical cannabidiol was returned to the dispensary from a patient or primary caregiver;

(2) The date the medical cannabidiol waste was collected;

(3) The quantity of medical cannabidiol waste collected; and

(4) The type and lot number of medical cannabidiol waste collected.

154.23(2) Medical cannabidiol and plant material waste. A manufacturer shall store, secure, and manage medical cannabidiol waste and plant material waste in accordance with all applicable federal, state, and local regulations.

a. The manufacturer shall dispose of medical cannabidiol waste at a waste facility according to federal and state law and in a manner which renders it unusable.

b. The manufacturer shall dispose of plant material waste at an approved solid waste disposal facility, according to federal and state law.

c. Before transport of plant material waste, the manufacturer shall render the plant material waste unusable and unrecognizable by grinding and incorporating the waste with a greater quantity of nonconsumable, solid wastes including:

(1) Paper waste;

(2) Cardboard waste;

(3) Food waste;

(4) Yard waste;

(5) Vegetative wastes generated from industrial or manufacturing processes that prepare food for human consumption;

(6) Soil; or

(7) Other waste approved by the department.

154.23(3) Liquid and chemical waste disposal. A manufacturer shall dispose of all liquid and chemical product waste generated in the process of cultivating, manufacturing, and distributing medical cannabidiol in accordance with all applicable federal, state, and local regulations.

154.23(4) Waste-tracking requirements. A manufacturer shall use forms approved by the department to maintain accurate and comprehensive records regarding waste material. The records shall account for, reconcile, and evidence all waste activity related to the disposal of medical cannabidiol waste and plant material waste.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4489C, IAB 6/5/19, effective 7/10/19; see Delay note at end of chapter]

641—154.24(124E) Record-keeping requirements.

154.24(1) Sales and distribution. A manufacturer shall maintain complete and accurate electronic sales transaction records in the department’s secure sales and inventory tracking system, including:

a. The date of each sale or distribution;

b. The item number, product name and description, and quantity of medical cannabidiol sold or otherwise distributed; and
c. The sale price.

154.24(2) Financial transactions. A manufacturer shall maintain records that reflect all financial transactions and the financial condition of the business. The following records shall be maintained for at least five years and made available for review, upon request of the department:

a. Purchase invoices, bills of lading, sales records, copies of bills of sale, and any supporting documents, to include the items or services purchased, from whom the items were purchased, and the date of purchase;

b. Bank statements and canceled checks for all business accounts;

c. Accounting and tax records;

d. Records of all financial transactions, including contracts and agreements for services performed or services received;

154.24(3) Other records.

a. A manufacturer shall maintain the following for at least five years, unless otherwise noted, and provide to the department upon request:

(1) All personnel records;

(2) Records of any theft, loss, or other unaccountability of any medical cannabidiol or plant material;

(3) Transport manifests and incident reports; and

(4) Records of all samples sent to a testing laboratory and the quality assurance test results.

b. A manufacturer shall maintain for at least one year and provide to the department upon request its controlled access system data and visitor manifests.

c. A manufacturer shall use the department’s secure sales and inventory tracking system to maintain the following:

(1) Crop input records;

(2) Production records;

(3) Transportation records; and

(4) Inventory records, including disposal of waste.

154.24(4) Entry into the department’s secure sales and inventory tracking system. Unless otherwise provided in these rules, a manufacturer shall adhere to the following schedule for entering data into the department’s secure sales and inventory tracking system.

a. A manufacturer shall enter data in real time for data related to:

(1) Transport of plant material, waste material, and laboratory samples; and

(2) Sales of medical cannabidiol to dispensaries.

b. A manufacturer shall enter data on changes to inventory of plant material, medical cannabidiol, and waste material by the end of the business day in which the changes occurred.

c. A manufacturer shall enter data within five business days for data related to:

(1) Application and use of crop inputs and other solvents and chemicals; and

(2) Other manufacturing and production records not related to inventory of plant material, medical cannabidiol, and waste material.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4489C, IAB 6/5/19, effective 7/10/19; see Delay note at end of chapter]

641—154.25(124E) Production requirements.

154.25(1) Cultivation and processing.

a. Only a licensed manufacturer is authorized to produce and manufacture medical cannabidiol.

b. All phases of production shall take place in designated, restricted access areas that are monitored by a surveillance camera system in accordance with rule 641—154.18(124E).

c. The production process shall be designed to limit contamination. Examples of contamination include mold, fungus, bacterial diseases, rot, pests, nonorganic pesticides, and mildew.

d. Each production area shall allow for access, observation, and inventory of each plant group.

e. Biosecurity measures shall be in effect as described in the operating documents pursuant to subrule 154.17(1).

154.25(2) Crop inputs and plant batches.
a. All crop inputs used by a manufacturer must be approved by the department prior to the first application of the input. A manufacturer shall email a request for approval of a crop input to the department. The subject line of the email shall read, “RESPONSE REQUIRED – Crop input approval request.” The department shall have up to 48 hours to respond with an approval or denial. A manufacturer may proceed with the application if the department does not reply within 48 hours of receiving the request. A crop input will remain approved unless or until the department withdraws the approval because of newly discovered product safety concerns. The department shall give a manufacturer written notification 48 hours before withdrawing an approval of a crop input.

b. The manufacturer shall use the department’s secure sales and inventory tracking system to maintain an electronic record of all crop inputs. The record shall include the following:
   (1) The date of input application;
   (2) The name of the employee applying the crop input;
   (3) The crop input that was applied;
   (4) The plants that received the application;
   (5) The amount of crop input that was applied; and
   (6) A copy of or electronic link to the safety data sheet for the crop input applied.

c. At the time of planting, all plants shall be tracked in a batch process with a unique batch number that shall remain with the batch through final processing into medical cannabidiol.

d. A manufacturer shall record any removal of plants from the batch, including the reason for removal, on a record maintained at the manufacturing facility for at least five years.

e. Each batch or part of a batch of cannabis plants that contributes to a lot of medical cannabidiol shall be recorded in the department’s secure sales and inventory tracking system or other manifest system.

154.25(3) Production of medical cannabidiol.

a. A manufacturer shall comply with all state and local building and fire code requirements.

b. A manufacturer shall obtain approval from the department for use of any hydrocarbon-based extraction process. Examples of a hydrocarbon-based extraction process include the use of butane, ethanol, hexane, and isopropyl alcohol.

c. Medical cannabidiol shall be prepared, handled, and stored in compliance with the sanitation requirements in this rule.

d. A manufacturer shall produce shelf-stable, nonperishable forms of medical cannabidiol.

e. A manufacturer shall ensure that the cannabinoid content of the medical cannabidiol it produces is homogenous.

f. Each lot of medical cannabidiol shall be assigned a unique lot number and recorded in the department’s secure sales and inventory tracking system or other manifest system.

154.25(4) General sanitation requirements. A manufacturer shall take all reasonable measures and precautions to ensure that:

a. Any employee who has a communicable disease does not perform any tasks that might contaminate plant material or medical cannabidiol;

b. Hand-washing facilities are:
   (1) Convenient and furnished with running water at a suitable temperature;
   (2) Located in all production areas; and
   (3) Equipped with effective hand-cleaning and -sanitizing preparations and sanitary towel service or electronic drying devices;

c. All employees working in direct contact with plant material and medical cannabidiol use hygienic practices while on duty, including:
   (1) Maintaining personal cleanliness; and
   (2) Washing hands thoroughly in a hand-washing area before starting work and at any other time when the hands may have become soiled or contaminated;

d. Litter and waste are routinely removed and the operating systems for waste disposal are routinely inspected;

e. Floors, walls, and ceilings are constructed with a surface that can be easily cleaned and maintained in good repair to inhibit microbial growth;
f. Lighting is adequate in all areas where plant material and medical cannabidiol are processed, stored, or sold;
g. Screening or other protection against the entry of pests is provided, including that rubbish is disposed of to minimize the development of odor and the potential for the waste becoming an attractant, harborage, or breeding place for pests;
h. Any buildings, fixtures, and other facilities are maintained in a sanitary condition;
i. Toxic cleaning compounds, sanitizing agents, and other potentially harmful chemicals are identified and stored in a separate location away from plant material and medical cannabidiol and in accordance with applicable local, state, or federal law;
j. All contact surfaces, utensils, and equipment used in the production of plant material and medical cannabidiol are maintained in a clean and sanitary condition;
k. The manufacturing facility water supply is sufficient for necessary operations;
l. Plumbing size and design meets operational needs and all applicable state and local laws;
m. Employees have accessible toilet facilities that are sanitary and in good repair; and
n. Plant material and medical cannabidiol that could support the rapid growth of undesirable microorganisms are isolated to prevent the growth of those microorganisms.

154.25(5) Storage.

a. A manufacturer shall store plant material and medical cannabidiol during production, transport, and testing to prevent diversion, theft, or loss, including ensuring that:
   (1) Plant material and medical cannabidiol are returned to a secure location immediately after completion of the process or at the end of the scheduled business day; and
   (2) The tanks, vessels, bins, or bulk containers containing plant material or medical cannabidiol are locked inside a secure area if a process is not completed at the end of a business day.

b. A manufacturer shall store all plant material and medical cannabidiol during production, transport, and testing, and all saleable medical cannabidiol:
   (1) In areas that are maintained in a clean, orderly, and well-ventilated condition; and
   (2) In storage areas that are free from infestation by insects, rodents, birds, and other pests of any kind.

c. To prevent degradation, a manufacturer shall store all plant material and medical cannabidiol in production, transport, and testing, and all saleable medical cannabidiol under conditions that will protect the product and its container against physical, chemical, and microbial contamination and deterioration.

d. A manufacturer shall maintain a separate secure storage area for medical cannabidiol that is returned from a dispensary, including medical cannabidiol that is outdated, damaged, deteriorated, mislabeled, or contaminated, or whose containers or packaging has been opened or breached, until the returned medical cannabidiol is destroyed. For purposes of this rule, a separate secure storage area includes a container, closet, or room that can be locked or secured.

[ARC 3686C; IAB 1/31/18, effective 3/7/18; ARC 4489C; IAB 6/5/19, effective 7/10/19; see Delay note at end of chapter]

641—154.26(124E) Quality assurance and control.

154.26(1) Quality control program. A manufacturer shall develop and implement a written quality assurance program that assesses the chemical and microbiological composition of medical cannabidiol. Assessment includes a profile of the active ingredients, including shelf life, and the presence of inactive ingredients and contaminants. A manufacturer shall use these testing results to determine appropriate storage conditions and product expiration dates.

154.26(2) Sampling protocols. A manufacturer shall develop and follow written procedures for sampling medical cannabidiol that require the manufacturer to:

a. Conduct sample collection in a manner that provides analytically sound and representative samples;

b. Document every sampling event and provide this documentation to the department upon request;

c. Describe all sampling and testing plans in written procedures that include the sampling method and the number of units per lot to be tested;
d. Ensure that random samples from each lot are:
   (1) Taken in an amount necessary to conduct the applicable test;
   (2) Labeled with the lot number; and
   (3) Submitted for testing;

f. Notify the department at least two business days prior to sample collection and allow the department or its designees to be present to observe the sampling procedures when the samples are to be sent to a laboratory for testing.

154.26(3) Sampling and testing. A manufacturer shall:

a. Work with the department and laboratory personnel to develop acceptance criteria for all potential contaminants based on the levels of metals, microbes, or other contaminants that the manufacturer uses in cultivating and producing medical cannabidiol;

b. Conduct sampling and testing of plant material and medical cannabidiol lots using acceptance criteria that are protective of patient health. The sampling and testing results shall be approved by the department and laboratory personnel and shall ensure that lots of medical cannabidiol meet allowable health risk limits for contaminants. Testing of plant material and lots shall occur as described in the laboratory testing requirements and acceptance criteria document described in subrule 154.69(1).

c. Refrain from packaging or selling medical cannabidiol from a process lot that fails to meet established standards, specifications, and any other relevant quality control criteria. Medical cannabidiol from a process lot that fails quality assurance testing may be remixed and retested;

d. Reject and destroy medical cannabidiol from a lot that fails to meet established standards, specifications, and any other relevant quality control criteria when remixing and retesting are not warranted;

e. Develop and follow a written procedure for responding to results failing to meet established standards, specifications, and any other relevant quality control criteria, including:
   (1) Criteria for when remixing and retesting are warranted;
   (2) Instructions for destroying contaminated or substandard medical cannabidiol as provided in subrule 154.23(2) when remixing and retesting are not warranted; and
   (3) Instructions for determining the source of contamination;

f. Retain documentation of test results, assessment, and destruction of medical cannabidiol for at least five years.

154.26(4) Stability testing.

a. The quality assurance program shall include procedures for performing stability testing of each product type produced to determine product expiration dates. The procedures shall describe:
   (1) Sample size and test intervals based on statistical criteria and departmental guidance pursuant to subrule 154.69(1) for each attribute examined to ensure valid stability estimates;
   (2) Storage conditions for samples retained for testing; and
   (3) Reliable and specific test methods.

b. Stability studies shall include:
   (1) Medical cannabidiol testing at appropriate intervals; and
   (2) Medical cannabidiol testing in the same container-closure system in which the medical cannabidiol is marketed and dispensed.

c. If product-expiration-date studies have not been completed before December 1, 2018, a manufacturer shall assign a tentative product expiration date, not to exceed one year, based on any available stability information. A manufacturer shall concurrently conduct stability studies to determine the actual product expiration date.

d. After a manufacturer verifies the tentative product expiration date, or determines the appropriate product expiration date, a manufacturer shall include that product expiration date on each lot of medical cannabidiol.

e. Stability testing shall be repeated if the manufacturing process or the product’s chemical composition is changed.

154.26(5) Reserve samples.
a. A manufacturer shall retain a uniquely labeled reserve sample that represents each lot of medical cannabidiol and store the reserve sample under conditions consistent with product labeling. The reserve sample shall be stored in the same immediate container-closure system in which the medical cannabidiol is marketed or in one that has similar characteristics. The reserve sample shall consist of at least twice the quantity necessary to perform all the required tests.

b. A manufacturer shall retain the reserve for at least two years from the date of manufacture.

c. After two years from the date of manufacture, reserve samples shall be destroyed as provided in subrule 154.23(2).

154.26(6) Retesting. If the department deems that public health may be at risk, the department may require the manufacturer to retest any sample of plant material or medical cannabidiol.

154.26(7) Disposal of substandard product. A manufacturer shall dispose of all medical cannabidiol as provided in subrule 154.23(2) when samples fail to meet established standards, specifications, and other relevant quality control criteria and when an adequate remedy for remixing and retesting as provided in paragraph 154.26(3)“c” is unavailable.

154.26(8) Recall and market withdrawal procedures. Each manufacturer shall establish a procedure for recalling or withdrawing from the market, as applicable, medical cannabidiol that has a reasonable probability of causing an unexpected or harmful response in a patient population, despite appropriate use, that outweighs the potential benefit of the medical cannabidiol. This procedure shall include:

a. Factors that make a recall or market withdrawal necessary;

b. Manufacturer’s personnel who are responsible for overseeing the recall or market withdrawal; and

c. How to notify affected parties of a recall or market withdrawal.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 3836C, IAB 6/6/18, effective 7/1/18; ARC 4078C, IAB 10/10/18, effective 11/14/18; ARC 4489C, IAB 6/5/19, effective 7/10/19; see Delay note at end of chapter]

641—154.27(124E) Supply and inventory.

154.27(1) Reliable and ongoing supply. A manufacturer shall provide a reliable and ongoing supply of medical cannabidiol to medical cannabidiol dispensaries.

154.27(2) Inventory controls and procedures. A manufacturer shall establish inventory controls and procedures for conducting inventory reviews to prevent and detect any diversion, theft, or loss in a timely manner.

154.27(3) Real-time inventory required. A manufacturer shall use the department-approved secure sales and inventory tracking system to track medical cannabidiol production from seed or plant cutting through distribution of medical cannabidiol to a dispensary. The manufacturer shall use the system to maintain a real-time record of the manufacturer’s inventory of plant material and medical cannabidiol to include:

a. The quantity and form of medical cannabidiol maintained by the manufacturer at the manufacturing facility on a daily basis;

b. The amount of plants being grown at the manufacturing facility on a daily basis;

c. The names of the employees or employee conducting the inventory; and

d. Other information deemed necessary and requested by the department.

154.27(4) Waste inventory. A manufacturer shall maintain a record of its inventory of all medical cannabidiol waste and plant material waste for disposal.

154.27(5) Reconciliation. No less often than every two calendar weeks, a manufacturer shall reconcile its physical inventory with the inventory recorded in the department’s secure sales and inventory tracking system.

a. Reconciliation shall include:

(1) Plant material at the manufacturing facility and in transit; and

(2) Medical cannabidiol at the manufacturing facility, at distribution and storage facilities, and in transit.

b. Discrepancies between the physical inventory of the manufacturer and the inventory recorded in the department’s secure sales and inventory system shall be handled as follows:
(1) A manufacturer shall report suspected diversion of plant material or medical cannabidiol to the department and law enforcement within 72 hours of discovery.

(2) A manufacturer shall have up to 72 hours to reconcile discrepancies in the manufacturer’s physical inventory with the inventory recorded in the secure sales and inventory tracking system. If the manufacturer cannot reconcile the manufacturer’s physical inventory with the secure sales and inventory tracking system’s inventory within 72 hours but diversion of plant material or medical cannabidiol is not suspected, the manufacturer shall immediately contact the department to report the discrepancy and to initiate a compliance action plan pursuant to paragraph 154.28(4) “b.”

154.27(6) Scales. All scales used to weigh usable plant material for purposes of these rules shall be certified in accordance with ISO/IEC Standard 17025, which is incorporated herein by reference. [ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4078C, IAB 10/10/18, effective 11/14/18]

641—154.28(124E) Inspection by department or independent consultant. A manufacturer is subject to reasonable inspection by the department, a department-approved consultant, or other agency pursuant to Iowa Code chapter 124E and these rules and as authorized by laws and regulations.

154.28(1) Types of inspections. Inspections may include:
   a. Aspects of the business operations;
   b. The manufacturing facility;
   c. Vehicles used for transport or delivery of medical cannabidiol or plant material;
   d. Financial information and inventory documentation;
   e. Physical and electronic security alarm systems; and
   f. Other inspections as determined by the department.

154.28(2) Local safety inspections. A manufacturer may be subject to inspection of its manufacturing facility and grounds by the local fire department, building inspector, or code enforcement officer to confirm that no health or safety concerns are present. The inspection could result in additional specific standards to meet local licensing authority restrictions related to medical cannabidiol manufacturing or other local businesses. An annual fire safety inspection may result in the required installation of fire suppression devices, or other means necessary for adequate fire safety.

154.28(3) Health and sanitary inspection. The department has discretion to determine when an inspection by an independent consultant is necessary. The following is a nonexhaustive list of examples that may justify an independent inspection:
   a. The department has reasonable grounds to believe that the manufacturer is in violation of one or more of the requirements set forth in these rules or other applicable public health or sanitary laws, rules or regulations; or
   b. The department has reasonable grounds to believe that the manufacturer was the cause or source of contamination of medical cannabidiol.

154.28(4) Compliance required. A manufacturer shall respond to deficiencies found during inspections or inventory reconciliation as follows:
   a. Deficiencies not related to inventory reconciliation.
      (1) Upon written notification by the department of deficiencies that do not involve reconciliation of inventory, a manufacturer shall have up to 30 days to submit an action plan to the department with proposed remedies and timelines for completion of the remedies.
      (2) The department shall have up to two weeks to accept or require revision of the action plan.
   b. Deficiencies related to inventory reconciliation.
      (1) Upon notifying the department that the manufacturer cannot reconcile the manufacturer’s physical inventory with the inventory recorded in the department’s secure sales and inventory tracking system, the manufacturer shall have up to two business days to submit an action plan to the department with proposed remedies and timelines for completion of the remedies.
      (2) The department shall have up to two business days to accept or require revision of the action plan.
c. Failure to complete actions in the action plan within the timelines mutually agreed upon by the manufacturer and the department shall result in assessment of penalties or in suspension or revocation of a manufacturer license as authorized by these rules.

d. At the department’s request and in a timely manner, a manufacturer shall pay for and undergo an independent health and sanitary inspection in accordance with this rule.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4078C, IAB 10/10/18, effective 11/14/18]

641—154.29(124E) Assessment of penalties. The department shall assess to a manufacturer a civil penalty of up to $1,000 per violation of Iowa Code chapter 124E or these rules in addition to other applicable penalties.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.30(124E) Suspension or revocation of a manufacturer license.

154.30(1) The department may suspend or revoke a manufacturer license upon any of the following grounds:

a. Submission of false, inaccurate, misleading, or fraudulent information to the department in the application or inspection processes.

b. Failure to submit required reports and documents.

c. Violation of Iowa Code chapter 124E or these rules, or violation of state or local law related to operation of the licensee.

d. Conduct or practices detrimental to the safety, health, or welfare of a patient, primary caregiver, or the public.

e. Criminal, civil, or administration action taken against a license or registration in this or another state or country related to manufacturing or dispensing medical cannabidiol.

f. False, misleading, or deceptive representations to the department, another state or federal agency, or a law enforcement agency.

g. Discontinuance of operation for more than 30 days, unless the department approves an extension of such period for good cause shown.

h. Failure to maintain effective controls against diversion, theft, or loss of medical cannabidiol.

i. Failure to correct a deficiency within the time frame required by the department.

j. Failure of a manufacturer’s business owner or investors to have a satisfactory result in a background investigation or national criminal history background check conducted by the department of public safety and as determined by the department.

154.30(2) The department shall notify the licensee of the proposed action pursuant to Iowa Code sections 17A.12 and 17A.18. Notice of issuance of a suspension or revocation shall be served by restricted certified mail, return receipt requested, or by personal service.

154.30(3) A request for appeal concerning the suspension or revocation of a license shall be submitted by the aggrieved party in writing to the department by certified mail, return receipt requested, within 20 days of the receipt of the department’s notice. The address is: Iowa Department of Public Health, Office of Medical Cannabidiol, Lucas State Office Building, Des Moines, Iowa 50319-0075. If such a request is made within the 20-day time period, the notice shall be deemed to be suspended. Prior to or at the hearing, the department may rescind the notice upon satisfaction that the reason for the suspension or revocation has been or will be removed. After the hearing or upon default of the applicant or alleged violator, the administrative law judge shall affirm, modify or set aside the suspension or revocation. If no request for appeal is received within the 20-day time period, the department’s notice of suspension or revocation shall become the department’s final agency action.

154.30(4) Upon receipt of an appeal that meets contested case status, the appeal shall be forwarded within five working days to the department of inspections and appeals. The information upon which the adverse action is based and any additional information which may be provided by the aggrieved party shall also be provided to the department of inspections and appeals.

154.30(5) The hearing shall be conducted according to the procedural rules of the department of inspections and appeals found in 481—Chapter 10.
154.30(6) When the administrative law judge makes a proposed decision and order, it shall be served by restricted certified mail, return receipt requested, or delivered by personal service. That proposed decision and order then becomes the department’s final agency action without further proceedings ten days after it is received by the aggrieved party unless an appeal to the director is taken.

154.30(7) Any appeal to the director for review of the proposed decision and order of the administrative law judge shall be filed in writing and mailed to the director by certified mail, return receipt requested, or delivered by personal service within ten days after the receipt of the administrative law judge’s proposed decision and order by the aggrieved party. A copy of the appeal shall also be mailed to the administrative law judge. Any request for an appeal shall state the reason for appeal.

154.30(8) Upon receipt of an appeal request, the administrative law judge shall prepare the record of the hearing for submission to the director. The record shall include the following:

a. All pleadings, motions, and rules.

b. All evidence received or considered and all other submissions by recording or transcript.

c. A statement of all matters officially noticed.

d. All questions and offers of proof, objections, and rulings thereon.

e. All proposed findings and exceptions.

f. The proposed decision and order of the administrative law judge.

154.30(9) The decision and order of the director becomes the department’s final agency action upon receipt by the aggrieved party and shall be delivered by restricted certified mail, return receipt requested, or by personal service.

154.30(10) It is not necessary to file an application for a rehearing to exhaust administrative remedies when appealing to the director or the district court as provided in Iowa Code section 17A.19. The aggrieved party to the final agency action of the department who has exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A.

154.30(11) Any petition for judicial review of a decision and order shall be filed in the district court within 30 days after the decision and order becomes final. A copy of the notice of appeal shall be sent to the department by certified mail, return receipt requested, or by personal service. The address is: Iowa Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075.

154.30(12) The party who appeals a final agency action to the district court shall pay the cost of the preparation of a transcript of the contested case hearing for the district court.

154.30(13) Emergency adjudicative proceedings.

a. Necessary emergency action. To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, and consistent with the Constitution and other provisions of law, the department may issue a written order in compliance with Iowa Code section 17A.18A 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.

b. Before issuing an emergency adjudicative order, the department shall consider factors including, but not limited to, the following:

(1) Whether there has been a sufficient factual investigation to ensure that the department is proceeding on the basis of reliable information;

(2) Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing;

(3) Whether the licensee required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare;

(4) Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare; and

(5) Whether the specific action contemplated by the department is necessary to avoid the immediate danger.

c. Issuance of order.

(1) An emergency adjudicative order shall contain findings of fact, conclusions of law, and policy reasons to justify the determination of an immediate danger in the department’s decision to take immediate action. The order is a public record.
(2) The written emergency adjudicative order shall be immediately delivered to the licensee that is required to comply with the order. The order shall be delivered by one or more of the following methods:
   1. Personal delivery.
   2. Certified mail, return receipt requested, to the last address on file with the department.
   3. Fax. Fax may be used as the sole method of delivery if the licensee required to comply with the order has filed a written request that agency orders be sent by fax and has provided a fax number for that purpose.
   3 To the degree practicable, the department shall select the procedure for providing written notice that best ensures prompt, reliable delivery.
   4. Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the department shall make reasonable immediate efforts to contact by telephone the licensee that is required to comply with the order.
   5. After the issuance of an emergency adjudicative order, the department shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger.
   6. Issuance of a written emergency adjudicative order shall include notification of the date on which department proceedings are scheduled for completion. After issuance of an emergency adjudicative order, continuance of further department proceedings to a later date will be granted only in compelling circumstances upon application in writing unless the licensee that is required to comply with the order is the party requesting the continuance.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4489C, IAB 6/5/19, effective 7/10/19]

641—154.31(124E) Closure of operations.

154.31(1) Notice. A manufacturer shall notify the department at least six months before the closure of the manufacturing facility.

154.31(2) Procedures. If a manufacturer ceases operation, the manufacturer shall work with the department to verify the remaining inventory of the manufacturer and ensure that any plant material, plant material waste, and medical cannabidiol are destroyed at a waste facility as provided in subrule 154.43(2).

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.32 to 154.39 Reserved.

DISPENSING

641—154.40(124E) Duties of the department.

154.40(1) Interagency agreements. The department may enter into any interagency agreements with other state agencies for technical services or other assistance related to the regulation or inspection of dispensaries.

154.40(2) Notice to law enforcement. The department shall notify local law enforcement agencies and the department of public safety of the locations of dispensaries. If the department has sufficient cause to believe that there is a threat to public safety, the department shall notify local law enforcement agencies and the department of public safety of any conditions that pose a threat to public safety including but not limited to:
   a. Loss or theft of medical cannabidiol;
   b. Diversion or potential diversion of medical cannabidiol;
   c. Unauthorized access to the secure sales and inventory tracking system or other patient and caregiver information system or file; or
   d. Other violations of law.

154.40(3) Inspection of dispensaries. The department or its agents shall conduct regular inspections of dispensaries and their facilities as described in rule 641—154.52(124E).
154.40(4) Establishment and maintenance of a secure sales and inventory tracking system. The department shall establish and maintain a secure, electronic system that is available 24 hours a day, seven days a week to track:
   a. Inventory of medical cannabidiol and waste material;
   b. Sales of medical cannabidiol from dispensaries to patients and primary caregivers.

154.40(5) Licensure and licensure renewal of dispensaries. The department shall issue a request for proposals to select and license by April 1, 2018, up to five dispensaries to dispense medical cannabidiol within the state consistent with the provisions of Iowa Code chapter 124E and these rules.
   a. To be eligible for licensure, an applicant dispensary shall provide information on forms and in a manner required by the department of public safety for the completion of a background investigation. In addition, the applicant dispensary shall submit to the department of public safety necessary funds to satisfy the full reimbursement of costs associated with completing the background investigations. If the applicant dispensary is not found suitable for licensure as a result of the background investigation, a license shall not be issued by the department.
   b. As a condition for licensure, an applicant dispensary shall agree to begin dispensing medical cannabidiol to patients and primary caregivers in Iowa no later than December 1, 2018.
   c. The initial license to dispense medical cannabidiol shall be valid from April 1, 2018, through November 30, 2018. The license shall be renewed annually unless a dispensary relinquishes the license, there is a change in state law prohibiting the department from renewing the license, or the license is revoked pursuant to Iowa Code chapter 124E or these rules.
   d. A license to dispense medical cannabidiol issued by the department pursuant to these rules is not assignable or transferable.
   e. The department shall consider the following factors in determining whether to select and license a medical cannabidiol dispensary:
      (1) Geographical location of the proposed dispensary facility;
      (2) The technical expertise of an applicant dispensary’s staff regarding medical cannabidiol;
      (3) The qualifications of an applicant dispensary’s employees;
      (4) The long-term financial stability of an applicant dispensary;
      (5) The ability of an applicant dispensary to provide appropriate security measures on the premises of the dispensary;
      (6) An applicant dispensary’s projection of and ongoing assessment of retail product costs, including any dispensing fees.
   f. Pursuant to Iowa Code section 124E.8(1) “h.” information submitted during the application process shall be confidential until an applicant dispensary is licensed by the department unless otherwise protected from disclosure under state or federal law.
   g. A licensed dispensary shall submit an application to renew its license with the department at least six months before the license expires. The application shall be submitted on a form created by the department.
   h. The department shall notify a dispensary of the decision to approve or deny the dispensary’s license by August 1 of the year in which the renewal application is submitted.

154.40(6) Collection of fees from dispensaries. Except as provided in this rule, all fees are nonrefundable, shall be retained by the department, and shall be considered repayment receipts as defined in Iowa Code section 8.2.
   a. Fees to the department.
      (1) One application is required for each dispensary location.
      (2) Each application for licensure as a dispensary shall include a nonrefundable application fee of $5,000.
      (3) Licensed dispensaries shall pay an annual fee to the department to cover costs associated with regulating and inspecting dispensaries and for other expenses necessary for the administration of the medical cannabidiol program. The department shall assess the fee with the notice of approval of license renewal each year on August 1, payable by the dispensary to the department no later than December 1.
   b. Fees to the department of public safety.
(1) An applicant dispensary shall be responsible to reimburse the department of public safety the full cost of conducting background investigations related to an application for licensure and operation as a licensed dispensary. The department of public safety shall retain the right to bill a dispensary for additional background investigations, as needed.

(2) Each dispensary submitting an application for licensure shall, at time of application, submit to the department of public safety a deposit of $10,000 for each business owner subject to a background investigation and a national criminal history background check. Background investigation costs shall be deducted from the funds deposited. If the background investigation fees exceed the funds deposited, the applicant shall submit additional funds as required by the department of public safety. If the background investigation fees are less than the funds deposited, the department of public safety may refund or retain the fees as mutually agreed with the dispensary.

(3) A licensed dispensary shall pay a deposit of $200 per employee to the department of public safety for a background investigation and a national criminal history background check on any person being considered for hire as an employee of the dispensary. Background investigation costs shall be deducted from the funds deposited. If the background investigation fees exceed the funds deposited, the dispensary shall submit additional funds as required by the department of public safety. If the background investigation fees are less than the funds deposited, the department of public safety may refund or retain the fees as mutually agreed with the dispensary. The department shall retain the right to preclude a potential employee from hire based upon the results of the background investigation and national criminal history background check.

154.40(7) Recall of medical cannabidiol products. The department may require a dispensary to recall medical cannabidiol from the dispensary facility and patients when there is potential for serious health consequences from use of the products as determined by the department. Situations that may require a recall include but are not limited to:

a. After consultation with the department’s medical director, it is determined that the distribution, sale, or use of the medical cannabidiol creates or poses an immediate and serious threat to human life or health, and

b. Other procedures available to the department to prevent or remedy a situation would result in an unreasonable delay that may place the health of patients at risk.

[ARC 3606C; IAB 1/31/18, effective 3/7/18; ARC 4489C, IAB 6/5/19, effective 7/10/19; see Delay note at end of chapter]

641—154.41(124E) Dispensary operations.

154.41(1) Operating documents. The operating documents of a dispensary shall include all of the following:

a. Procedures for the oversight of the dispensary, including descriptions of operational and management practices regarding:

(1) The forms and quantities of medical cannabidiol products that will be stored and dispensed at the dispensary;

(2) The estimated forms and quantities of medical cannabidiol waste to be generated or collected;

(3) The disposal methods for all waste materials;

(4) Employee training methods for the dispensary employees;

(5) Strategies for identifying and reconciling discrepancies in inventory of medical cannabidiol;

(6) Medical cannabidiol labeling procedures;

(7) Procedures for recall or market withdrawal of medical cannabidiol;

(8) Plans for responding to a security breach at the dispensary facility;

(9) A business continuity plan; and

(10) Other information requested by the department.

b. Procedures to ensure accurate record keeping.

c. Procedures for the implementation of appropriate security measures to deter and prevent the theft of medical cannabidiol and unauthorized entrance into areas of the dispensary facility containing medical cannabidiol.

154.41(2) Prohibited activities.
a. A person or entity shall not own or operate a dispensary unless the person or entity is licensed by the department pursuant to Iowa Code chapter 124E and these rules.

b. A dispensary shall not:
   (1) Dispense medical cannabidiol in any location except in those areas approved by the department;
   (2) Sell, receive, transport, or distribute medical cannabidiol from any location except its dispensary;
   (3) Sell, receive, or distribute medical cannabidiol from any entity other than a manufacturer licensed by the department;
   (4) Sell or distribute medical cannabidiol to any person other than an approved patient or primary caregiver;
   (5) Transport or deliver medical cannabidiol to any location, unless approved by the department;
   (6) Sell medical cannabidiol that is not packaged and labeled in accordance with rules 641—154.21(124E) and 641—154.46(124E);
   (7) Repackage medical cannabidiol or remove the manufacturer’s label;
   (8) Sell medical cannabidiol in any form or quantity other than a form or quantity approved by the department and adopted by rule;
   (9) Permit any person to consume medical cannabidiol on the property of the dispensary;
   (10) Employ a person who is under 18 years of age or who has been convicted of a disqualifying felony offense.

154.41(3) Criminal background checks.

a. An owner of a dispensary shall not have been convicted of a disqualifying felony offense and shall be subject to a background investigation conducted by the department of public safety, including but not limited to a national criminal history background check.

b. An employee of a dispensary shall not have been convicted of a disqualifying felony offense and shall be subject to a background investigation conducted by the department of public safety, including but not limited to a national criminal history background check.

c. An applicant or licensed dispensary shall respond within 30 days to a request from the department or the department of public safety for more information to complete a background investigation and national criminal history background check on an owner, investor, or employee.

154.41(4) Relationship to health care practitioners. A dispensary shall not share office space with, refer patients to, or have any financial relationship with a health care practitioner.

[ARC 3606C, IAB 1/31/18, effective 5/7/18; ARC 4489C, IAB 6/5/19, effective 7/10/19]

641—154.42(124E) Security requirements. The department may request assistance from the department of public safety in ensuring dispensaries meet the security requirements in this rule.

154.42(1) Restricted access. A dispensary shall have a controlled access system to limit entrance to all restricted access areas of the dispensary facility. Visitors to restricted access areas shall sign manifests with name, date, and times of entry and exit, if the controlled access system cannot electronically record visitors. Visitors shall wear badges that are visible at all times and identify them as visitors.

a. The controlled access system shall do all of the following:
   (1) Limit access to authorized individuals;
   (2) Maintain a log of individuals with approved access, including dates of approvals and revocations;
   (3) Track times of personnel entry to and exit from restricted access areas;
   (4) Store data for retrieval for a minimum of one year; and
   (5) Limit access to authorized individuals in the event of a power failure.

b. A dispensary shall promptly, but no later than five business days after receipt of request, submit stored controlled access system data to the department.

c. Separate written manifests of visitors to restricted access areas shall be kept and stored for a minimum of one year if the controlled access system does not include electronic records of visitors to the restricted access areas.
d. Restricted access areas shall be identified with signs that state: “Do Not Enter – Restricted Access Area – Access Limited to Authorized Personnel Only.”

154.42(2) Perimeter intrusion detection system.

a. Computer-controlled video surveillance system. A dispensary shall operate and maintain in good working order a computer-controlled, closed-circuit television surveillance system on its premises that operates 24 hours per day, seven days a week, and visually records:
   (1) All areas that might contain medical cannabidiol, including all safes, vaults, and storage areas;
   (2) All points of entry and exit;
   (3) The entrance to the video surveillance control room; and
   (4) Parking areas, which shall have appropriate lighting for the normal conditions of the area under surveillance.

b. Camera specifications. Cameras shall:
   (1) Capture clear and certain identification of any person entering or exiting a dispensary or its parking areas to the extent identification is technologically feasible with generally accepted commercial security cameras;
   (2) Have the ability to produce a clear, color still photograph live or from a recording;
   (3) Have on all recordings an embedded date-and-time stamp that is synchronized to the recording and does not obscure the picture; and
   (4) Continue to operate during a power outage.

c. Video recording specifications.
   (1) A video recording shall export still images in an industry standard image format, such as .jpg, .bmp, or .gif.
   (2) Exported video shall be archived in a format that ensures authentication and guarantees that the recorded image has not been altered.
   (3) Exported video shall also be saved in an industry standard file format that can be played on a standard computer operating system.
   (4) All recordings shall be erased or destroyed at the end of the retention period and prior to disposal of any storage medium.

d. Additional requirements. A dispensary shall maintain all security system equipment and recordings in a secure location to prevent theft, loss, destruction, corruption, and alterations.

  e. Retention. A dispensary shall ensure that recordings from all video cameras are:
     (1) Available for viewing by the department upon request;
     (2) Retained for at least 60 days;
     (3) Maintained free of alteration or corruption; and
     (4) Retained longer, as needed, if a dispensary is given actual notice of a pending criminal, civil, or administrative investigation, or other legal proceeding for which the recording may contain relevant information.

  f. Required signage. A dispensary shall post a sign in capital letters in a conspicuous location at every entrance to the dispensary that reads, “THESE PREMISES ARE UNDER CONSTANT VIDEO SURVEILLANCE.”

154.42(3) Security alarm system requirements.

a. A dispensary shall install and maintain a professionally monitored security alarm system that provides intrusion and fire detection of all:
   (1) Dispensary entrances and exits;
   (2) Rooms with exterior windows;
   (3) Rooms with exterior walls;
   (4) Roof hatches;
   (5) Skylights; and
   (6) Storage rooms.

b. For the purposes of this subrule, a security alarm system means a device or series of devices that summons law enforcement personnel during, or as a result of, an alarm condition. Devices may include:
(1) Hardwired systems and systems interconnected with a radio frequency method such as cellular or private radio signals that emit or transmit a remote or local audio, visual, or electronic signal;
(2) Motion detectors;
(3) Pressure switches;
(4) A duress alarm;
(5) A panic alarm;
(6) A holdup alarm;
(7) An automatic voice dialer; and
(8) A failure notification system that provides an audio, text, or visual notification of any failure in the surveillance system.

c. A dispensary’s security alarm system and all devices shall continue to operate during a power outage.

d. A dispensary’s security alarm system shall be inspected and all devices tested annually by a qualified alarm vendor. A dispensary shall provide documentation of the annual inspection and device testing to the department upon request.

154.42(4) Personnel identification system. A dispensary shall use a personnel identification system that controls and monitors individual employee access to restricted access areas within the dispensary and that meets the requirements of this subrule and subrule 154.42(1).

a. Requirement for employee identification card. An employee identification card shall contain:
   (1) The name of the employee;
   (2) The date of issuance and expiration;
   (3) An alphanumeric identification number that is unique to the employee; and
   (4) A photographic image of the employee.

b. A dispensary’s employees shall keep the identification card visible at all times when the employee is in a dispensary or a vehicle transporting medical cannabidiol.

c. Upon termination or resignation of an employee, a dispensary shall immediately:
   (1) Revoke the employee’s access to restricted access areas of the dispensary; and
   (2) Obtain and destroy the employee’s identification card, if possible.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.43(124E) Location. All dispensing of medical cannabidiol shall take place in an enclosed facility at one physical address provided to the department during the licensure process.

154.43(1) Proximity to manufacturers. A dispensary shall not operate at the same physical location as a manufacturer.

154.43(2) Proximity to schools. A dispensary shall not operate in any location within 1,000 feet of a public or private school existing before the date of the dispensary’s licensure by the department.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.44(124E) Advertising and marketing.

154.44(1) Permitted marketing and advertising activities.

a. A dispensary may:
   (1) Display the dispensary’s business name and logo on medical cannabidiol labels, signs, website, and informational material provided to patients. The name or logo shall not include:
      1. Images of cannabis or cannabis-use paraphernalia;
      2. Colloquial references to cannabis;
      3. Names of cannabis plant strains or varieties;
      4. Unsubstantiated medical claims; or
      5. Medical symbols that bear a reasonable resemblance to established medical associations. Examples of established medical organizations include the American Medical Association or American Academy of Pediatrics. The use of medical symbols is subject to approval by the department.
   (2) Display signs on the dispensary; and
   (3) Maintain a business website that contains the following information:
      1. The dispensary’s name and contact information;
2. The medical cannabidiol forms and quantities provided;
3. Medical cannabidiol pricing;
4. Hours of operation; and
5. Other information as approved by the department.
   b. The business website shall not include any false, misleading, or unsubstantiated statements.
   c. The department reserves the right to review a dispensary’s marketing and advertising materials and to require a dispensary to make changes to the content. The department has 30 calendar days following submission to approve or deny marketing and advertising materials of a dispensary.

154.44(2) Other marketing and advertising activities. A dispensary shall request and receive the department’s written approval before beginning marketing or advertising activities that are not specified in subrule 154.44(1). The department has 30 calendar days to approve, deny, or request additional information regarding marketing and advertising activity requests from a dispensary. In the event the department fails to respond to a dispensary within 30 days with an approval, denial, or request for additional information, the dispensary’s marketing and advertising activity requests shall be deemed approved.

154.44(3) Inconspicuous display. A dispensary shall arrange displays of medical cannabidiol, interior signs, and other exhibits to reasonably prevent public viewing from outside the dispensary.

[ARC 3606C; IAB 1/31/18, effective 3/7/18]

641—154.45(124E) Storage.

154.45(1) Storage of saleable medical cannabidiol.
   a. A dispensary shall store medical cannabidiol to prevent diversion, theft, or loss, including ensuring that:
      (1) Medical cannabidiol is kept in a secure and monitored location within the dispensary; and
      (2) Cabinets or storage containers inside the secure and monitored area are locked at the end of a business day.
   b. A dispensary shall store all medical cannabidiol:
      (1) In areas that are maintained in a clean, orderly, and well-ventilated condition;
      (2) In areas that are free from infestation by insects, rodents, birds, and other pests of any kind;
      (3) According to the manufacturer’s requirements regarding temperature, light exposure, or other environmental conditions;
      (4) Under conditions that will protect the product and its container against physical, chemical, and microbial contamination and deterioration.

154.45(2) Storage of returned medical cannabidiol. A dispensary shall maintain a separate secure storage area for medical cannabidiol that is to be returned to a manufacturer for disposal, including medical cannabidiol that is outdated, damaged, deteriorated, mislabeled, or contaminated, or whose containers or packaging has been opened or breached, until the medical cannabidiol is collected by a manufacturer. For purposes of this subrule, a separate secure storage area includes a container, closet, or room that can be locked or secured.

[ARC 3606C; IAB 1/31/18, effective 3/7/18]

641—154.46(124E) Dispensing.

154.46(1) Access to all forms of product. A dispensary shall provide access to all medical cannabidiol forms produced by each licensed manufacturer.

154.46(2) Dispensing to a patient.
   a. Prior to dispensing any medical cannabidiol to a patient, a dispensary shall do all of the following:
      (1) Verify the patient’s identity;
      (2) Verify that the patient is registered and listed in the secure sales and inventory tracking system and has a valid medical registration card;
      (3) Assign a tracking number to any medical cannabidiol that is to be dispensed to the patient;
      (4) Issue a label that contains the following information:
         1. The medical cannabidiol tracking number; and
2. The patient registration number;
   (5) Ensure the following information, which may be printed on a secondary label or package insert, is issued with dispensed medical cannabidiol:
   1. The date and time the medical cannabidiol is dispensed;
   2. The name and address of the dispensary;
   3. Any specific instructions for use based upon manufacturer guidelines or department rules.
Text shall not include any false, misleading, or unsubstantiated statements regarding health or physical benefits to the patient.
   b. The dispensary shall record the patient name, the amount dispensed, the price, the medical cannabidiol tracking number, the time and date, and other information required by the department in the secure sales and inventory tracking system within one business day.

154.46(3) Dispensing to a primary caregiver:
   a. Prior to dispensing any medical cannabidiol to a primary caregiver, a dispensary shall do all of the following:
      (1) Verify the primary caregiver’s identity;
      (2) Verify that the patient and the primary caregiver are registered and listed in the secure sales and inventory tracking system and have valid medical registration cards;
      (3) Assign a medical cannabidiol tracking number to any medical cannabidiol that is to be dispensed to the primary caregiver;
      (4) Issue a label that contains the following information:
         1. The medical cannabidiol tracking number; and
         2. The patient registration number;
      (5) Ensure the following information, which may be printed on a secondary label or package insert, is issued with dispensed medical cannabidiol:
         1. The date and time the medical cannabidiol is dispensed;
         2. The name and address of the dispensary;
         3. Any specific instructions for use based upon manufacturer guidelines or department rules.
Text shall not include any false, misleading, or unsubstantiated statements regarding health or physical benefits to the patient.
   b. The dispensary shall record the names of the patient and primary caregiver, the amount dispensed, the price, the medical cannabidiol tracking number, the time and date, and other information required by the department in the secure sales and inventory tracking system within one business day.
[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4489C, IAB 6/5/19, effective 7/10/19]

641—154.47(124E) Transportation of medical cannabidiol. A dispensary is not authorized to transport medical cannabidiol, unless approved by the department. Any approved transport shall be logged in the secure sales and inventory tracking system.
[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.48(124E) Disposal of medical cannabidiol.
   154.48(1) Identification of excess, expired, or damaged medical cannabidiol.
      a. Dispensaries shall identify unused, excess, expired, or damaged medical cannabidiol for return to manufacturers.
      b. Unused, excess, expired, or damaged medical cannabidiol shall be stored as described in subrule 154.45(2).
   154.48(2) Return of medical cannabidiol from a patient or primary caregiver to a dispensary.
      a. A dispensary shall accept at no charge medical cannabidiol waste from any patient or primary caregiver. A dispensary shall provide all medical cannabidiol waste to the manufacturer for disposal.
      b. The dispensary shall enter the following information into the secure sales and inventory tracking system for all medical cannabidiol returned from a patient or primary caregiver:
         (1) The tracking number assigned at the time of the dispensing, if available, or the name of the patient, if the tracking number is unavailable, when the medical cannabidiol was returned to the dispensary from a patient or primary caregiver;
(2) The date the medical cannabinoid was returned;
(3) The quantity of medical cannabinoid returned; and
(4) The type and lot number of medical cannabinoid returned.

c. A dispensary shall store medical cannabinoid returned from patients and primary caregivers as described in subrule 154.45(2).

154.48(3) Return of medical cannabinoid to a manufacturer.

a. A manufacturer shall collect and dispose of medical cannabinoid from dispensaries as provided in rule 641—154.23(124E).

b. A dispensary shall record information on all medical cannabinoid collected by the manufacturer in the secure sales and inventory tracking system. Information shall include:
   (1) The date the medical cannabinoid was collected by the manufacturer;
   (2) The quantity of medical cannabinoid collected; and
   (3) The type and lot number of medical cannabinoid collected.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4489C, IAB 6/5/19, effective 7/10/19; see Delay note at end of chapter]

641—154.49(124E) Record-keeping requirements.

154.49(1) Sales. A dispensary shall maintain complete and accurate electronic sales transaction records in the department’s secure sales and inventory tracking system, including:

a. The name of the patient and, if purchase is made by the primary caregiver, the name of the primary caregiver;

b. The date of each sale;

c. The item number, product name and description, and quantity of medical cannabinoid sold;

d. The sale price;

e. Other information required by the department.

154.49(2) Financial transactions. A dispensary shall maintain records that reflect all financial transactions and the financial condition of the business. The following records shall be maintained for at least five years and made available for review, upon request of the department:

a. Purchase invoices, bills of lading, sales records, copies of bills of sale, and any supporting documents, to include the items or services purchased, from whom the items were purchased, and the date of purchase;

b. Bank statements and canceled checks for all business accounts;

c. Accounting and tax records;

d. Records of all financial transactions, including contracts and agreements for services performed or services received.

154.49(3) Other records.

a. A dispensary shall maintain the following for at least five years, unless otherwise noted, and provide to the department upon request:

   (1) All personnel records; and

   (2) Records of any theft, loss, or other unaccountability of any medical cannabinoid.

b. A dispensary shall maintain for at least one year and provide to the department upon request its controlled access system data and visitor manifests.

c. A dispensary shall use the department’s secure sales and inventory tracking system to maintain the following:

   (1) Inventory records;

   (2) Return of medical cannabinoid from a patient or primary caregiver; and

   (3) Return of unused, excess, expired, or damaged medical cannabinoid to a manufacturer.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.50(124E) Quality assurance and control. A dispensary shall cooperate with manufacturers and the department on quality assurance and control procedures, including participating in stability-testing studies, developing sampling strategies, and returning medical cannabinoid that has been recalled or withdrawn from the market.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]
641—154.51(124E) Inventory.

154.51(1) Inventory controls and procedures. A dispensary shall establish inventory controls and procedures for conducting inventory reviews to prevent and detect any diversion, theft, or loss in a timely manner.

154.51(2) Real-time inventory required. A dispensary shall use the department-approved secure sales and inventory tracking system to maintain a real-time record of the dispensary’s inventory of medical cannabidiol to include:

a. The quantity and form of saleable medical cannabidiol maintained at the dispensary on a daily basis;

b. The amount of damaged, expired, or returned medical cannabidiol being held at the dispensary for return to a manufacturer; and

c. Other information deemed necessary and requested by the department.

154.51(3) Reconciliation. At least once a calendar week, a dispensary shall reconcile all medical cannabidiol at the dispensary with the inventory recorded in the department’s secure sales and inventory tracking system. Discrepancies shall be handled as follows:

a. A dispensary shall report suspected diversion of medical cannabidiol to the department and law enforcement within 24 hours of discovery.

b. A dispensary shall have up to 24 hours to reconcile the dispensary’s physical inventory with the inventory recorded in the secure sales and inventory tracking system. If the dispensary cannot reconcile the dispensary’s physical inventory with the secure sales and inventory tracking system’s inventory within 24 hours but diversion of product is not suspected, the dispensary shall immediately contact the department to report the discrepancy and to initiate a compliance action plan pursuant to paragraph 154.52(4) “b.”

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4078C, IAB 10/10/18, effective 11/14/18]

641—154.52(124E) Inspection by department or independent consultant. A dispensary is subject to reasonable inspection by the department, a department-approved consultant, or other agency as authorized by Iowa Code chapter 124E and these rules or state or local laws and regulations.

154.52(1) Types of inspections. Inspections may include:

a. Aspects of the business operations;

b. The physical location of a dispensary, including any storage facilities;

c. Financial information and inventory documentation;

d. Physical and electronic security alarm systems; and

e. Other aspects or areas as determined by the department.

154.52(2) Local safety inspections. A dispensary may be subject to inspection of its dispensary by the local fire department, building inspector, or code enforcement officer to confirm that no health or safety concerns are present. The inspection could result in additional specific standards to meet local licensing authority restrictions related to medical cannabidiol dispensing or other local businesses. An annual fire safety inspection may result in the required installation of fire suppression devices, or other means necessary for adequate fire safety.

154.52(3) Health and sanitary inspection. The department has discretion to determine when an inspection by an independent consultant is necessary. The following is a nonexhaustive list of examples that may justify an independent inspection:

a. The department has reasonable grounds to believe that the dispensary is in violation of one or more of the requirements set forth in these rules or other applicable public health or sanitary laws, rules or regulations;

b. The department has reasonable grounds to believe that the dispensary was the cause or source of contamination of medical cannabidiol; or

c. The department has reasonable grounds to believe that the dispensary was the cause of loss of product quality or change in chemical composition due to improper storage and handling of medical cannabidiol.
154.52(4) Compliance required. A dispensary shall respond to deficiencies found during inspections or inventory reconciliation as follows:
   a. Deficiencies not related to inventory reconciliation.
      (1) Upon written notification by the department of deficiencies that do not involve reconciliation of inventory, a dispensary shall have up to 30 days to submit an action plan to the department with proposed remedies and timelines for completion of the remedies.
      (2) The department shall have up to two weeks to accept or require revision of the action plan.
   b. Deficiencies related to inventory reconciliation.
      (1) Upon notifying the department that the dispensary cannot reconcile the dispensary’s physical inventory with the inventory recorded in the department’s secure sales and inventory tracking system, the dispensary shall have up to two business days to submit an action plan to the department with proposed remedies and timelines for completion of the remedies.
      (2) The department shall have up to two business days to accept or require revision of the action plan.
   c. Failure to complete actions in the action plan within the timelines mutually agreed upon by the dispensary and the department shall result in assessment of penalties or in suspension or revocation of a dispensary license as authorized by these rules.
   d. At the department’s request and in a timely manner, a dispensary shall pay for and undergo an independent health and sanitary inspection in accordance with this rule.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4078C, IAB 10/10/18, effective 11/14/18]

641—154.53(124E) Assessment of penalties. The department shall assess to a dispensary a civil penalty of up to $1,000 per violation of Iowa Code chapter 124E or these rules in addition to other applicable penalties.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.54(124E) Suspension or revocation of a dispensary license.

154.54(1) The department may suspend or revoke a dispensary license upon any of the following grounds:
   a. Submission of false, inaccurate, misleading, or fraudulent information to the department in the application or inspection processes.
   b. Failure to submit required reports and documents.
   c. Violation of Iowa Code chapter 124E or these rules, or violation of state or local law related to operation of the licensee.
   d. Conduct or practices detrimental to the safety, health, or welfare of a patient, primary caregiver, or the public.
   e. Criminal, civil, or administration action taken against a license or registration in this or another state or country related to manufacturing or dispensing medical cannabidiol.
   f. False, misleading, or deceptive representations to the department, another state or federal agency, or a law enforcement agency.
   g. Discontinuance of operation for more than 30 days, unless the department approves an extension of such period for good cause shown.
   h. Failure to maintain effective controls against diversion, theft, or loss of medical cannabidiol.
   i. Failure to correct a deficiency within the time frame required by the department.
   j. Failure of a dispensary’s business owner to have a satisfactory result in a background investigation or national criminal history background check conducted by the department of public safety and as determined by the department.

154.54(2) The department shall notify the licensee of the proposed action pursuant to Iowa Code sections 17A.12 and 17A.18. Notice of issuance of a suspension or revocation shall be served by restricted certified mail, return receipt requested, or by personal service.

154.54(3) A request for appeal concerning the suspension or revocation of a license shall be submitted by the aggrieved party in writing to the department by certified mail, return receipt requested, within 20 days of the receipt of the department’s notice. The address is: Iowa Department of Public
Health, Office of Medical Cannabidiol, Lucas State Office Building, Des Moines, Iowa 50319-0075. If such a request is made within the 20-day time period, the notice shall be deemed to be suspended. Prior to or at the hearing, the department may rescind the notice upon satisfaction that the reason for the suspension or revocation has been or will be removed. After the hearing or upon default of the applicant or alleged violator, the administrative law judge shall affirm, modify or set aside the suspension or revocation. If no request for appeal is received within the 20-day time period, the department’s notice of suspension or revocation shall become the department’s final agency action.

154.54(4) Upon receipt of an appeal that meets contested case status, the appeal shall be forwarded within five working days to the department of inspections and appeals. The information upon which the adverse action is based and any additional information which may be provided by the aggrieved party shall also be provided to the department of inspections and appeals.

154.54(5) The hearing shall be conducted according to the procedural rules of the department of inspections and appeals found in 481—Chapter 10.

154.54(6) When the administrative law judge makes a proposed decision and order, it shall be served by restricted certified mail, return receipt requested, or delivered by personal service. That proposed decision and order then becomes the department’s final agency action without further proceedings ten days after it is received by the aggrieved party unless an appeal to the director is taken.

154.54(7) Any appeal to the director for review of the proposed decision and order of the administrative law judge shall be filed in writing and mailed to the director by certified mail, return receipt requested, or delivered by personal service within ten days after the receipt of the administrative law judge’s proposed decision and order by the aggrieved party. A copy of the appeal shall also be mailed to the administrative law judge. Any request for an appeal shall state the reason for appeal.

154.54(8) Upon receipt of an appeal request, the administrative law judge shall prepare the record of the hearing for submission to the director. The record shall include the following:

a. All pleadings, motions, and rules.
b. All evidence received or considered and all other submissions by recording or transcript.
c. A statement of all matters officially noticed.
d. All questions and offers of proof, objections, and rulings thereon.
e. All proposed findings and exceptions.
f. The proposed decision and order of the administrative law judge.

154.54(9) The decision and order of the director becomes the department’s final agency action upon receipt by the aggrieved party and shall be delivered by restricted certified mail, return receipt requested, or by personal service.

154.54(10) It is not necessary to file an application for a rehearing to exhaust administrative remedies when appealing to the director or the district court as provided in Iowa Code section 17A.19. The aggrieved party to the final agency action of the department who has exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A.

154.54(11) Any petition for judicial review of a decision and order shall be filed in the district court within 30 days after the decision and order becomes final. A copy of the notice of appeal shall be sent to the department by certified mail, return receipt requested, or by personal service. The address is: Iowa Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075.

154.54(12) The party who appeals a final agency action to the district court shall pay the cost of the preparation of a transcript of the contested case hearing for the district court.

154.54(13) Emergency adjudicative proceedings.

a. Necessary emergency action. To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, and consistent with the Constitution and other provisions of law, the department may issue a written order in compliance with Iowa Code section 17A.18A 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.

b. Before issuing an emergency adjudicative order, the department shall consider factors including, but not limited to, the following:
(1) Whether there has been a sufficient factual investigation to ensure that the department is proceeding on the basis of reliable information;
(2) Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing;
(3) Whether the licensee required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare;
(4) Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare; and
(5) Whether the specific action contemplated by the department is necessary to avoid the immediate danger.

c. Issuance of order.
   (1) An emergency adjudicative order shall contain findings of fact, conclusions of law, and policy reasons to justify the determination of an immediate danger in the department’s decision to take immediate action. The order is a public record.
   (2) The written emergency adjudicative order shall be immediately delivered to the licensee that is required to comply with the order. The order shall be delivered by one or more of the following methods:
      1. Personal delivery.
      2. Certified mail, return receipt requested, to the last address on file with the department.
      3. Fax. Fax may be used as the sole method of delivery if the licensee required to comply with the order has filed a written request that agency orders be sent by fax and has provided a fax number for that purpose.
   (3) To the degree practicable, the department shall select the procedure for providing written notice that best ensures prompt, reliable delivery.
   (4) Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the department shall make reasonable immediate efforts to contact by telephone the licensee that is required to comply with the order.
   (5) After the issuance of an emergency adjudicative order, the department shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger.
   (6) Issuance of a written emergency adjudicative order shall include notification of the date on which department proceedings are scheduled for completion. After issuance of an emergency adjudicative order, continuance of further department proceedings to a later date will be granted only in compelling circumstances upon application in writing unless the licensee that is required to comply with the order is the party requesting the continuance.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]


154.55 Notice. A dispensary shall notify the department at least six months before the closure of the dispensary.

154.55(2) Procedures. If a dispensary ceases operation, the dispensary shall work with the department to verify the remaining inventory of the dispensary and ensure that any medical cannabidiol is returned to a manufacturer.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.56 to 154.59 Reserved.

MEDICAL CANNABIDIOL BOARD

641—154.60(124E) Purpose and duties of board.

154.60(1) The purpose of the board is to administer the provisions of Iowa Code section 124E.5.

154.60(2) Responsibilities of the board include but are not limited to:
a. Accepting and reviewing petitions to add medical conditions, medical treatments, or debilitating diseases to the list of debilitating medical conditions for which the medical use of cannabidiol would be medically beneficial under Iowa Code chapter 124E.
b. Making recommendations to the board of medicine relating to the removal or addition of debilitating medical conditions to the list of allowable debilitating medical conditions for which the medical use of cannabidiol under Iowa Code chapter 124E would be medically beneficial.
c. Working with the department regarding the requirements for the licensure of manufacturers and dispensaries, including licensure procedures.
d. Advising the department regarding the location of manufacturers and dispensaries throughout the state.
e. Making recommendations to the board of medicine relating to the form and quantity of allowable medical uses of cannabidiol.
f. Considering recommendations to the general assembly for statutory revisions to the definition of medical cannabidiol to increase the tetrahydrocannabinol (THC) level to more than 3 percent.
g. Submitting an annual report to the general assembly detailing the activities of the board no later than January 1.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.61(124E) Organization of board and proceedings.

154.61(1) Membership. The board shall be composed of nine members appointed by the governor pursuant to Iowa Code section 124E.5. The appointments, unless provided otherwise by law, shall be for three-year staggered terms which shall expire on June 30. Board members shall be knowledgeable about the use of medical cannabidiol. The medical practitioners appointed to the board shall be licensed in Iowa and be nationally board-certified in their area of specialty.

154.61(2) Vacancies. Vacancies shall be filled in the same manner in which the original appointments were made for the balance of the unexpired term.

154.61(3) Absences. Three consecutive unexcused absences shall be grounds for the governor to consider dismissal of a board member and to appoint another. Department staff is charged with providing notification of absences to the governor’s office.

154.61(4) Board meetings.

a. The board shall convene at least twice but no more than four times a year.

b. Board meetings shall be conducted in accordance with the open meetings requirements of Iowa Code chapter 21.

c. The department’s office of medical cannabidiol shall schedule the time, date and location of meetings.

d. A majority of the members shall constitute a quorum for conducting business of the board.

e. An affirmative vote of a majority of the board members present at a meeting is required for a motion to pass.

154.61(5) Facilities and staffing. The department shall furnish the board with the necessary facilities and employees to perform the duties required by this chapter but shall be reimbursed for all costs incurred by fee revenue generated from licensing activities and registration card applications.

154.61(6) Subcommittees. The board may designate one or more subcommittees to perform such duties as may be deemed necessary.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.62(124E) Official communications. All official communications, including submissions, petitions and requests, may be addressed to the Medical Cannabidiol Board, Office of Medical Cannabidiol, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319-0075.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.63(124E) Office hours. The board office is open for public business from 8 a.m. to 4:30 p.m., Monday to Friday of each week, except holidays.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]
641—154.64(124E) Public meetings. Members of the public may be present during board meetings unless the board votes to hold a closed session. Dates and location of board meetings may be obtained through the Iowa department of public health’s website (idph.iowa.gov/mcarep) or directly from the board office.

154.64(1) Exclusion of participants. The person presiding at a meeting of the board may exclude a person from an open meeting for behavior that obstructs the meeting.

154.64(2) Recording of meetings. Cameras and recording devices may be used at open meetings, provided the cameras or recording devices do not obstruct the meeting. If the user of a camera or recording device obstructs the meeting by the use of such device, the presiding department staff member at the meeting may request the user to discontinue use of the camera or device.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.65(124E) Petitions for the addition or removal of medical conditions, medical treatments or debilitating diseases. Petitions for the addition or removal of medical conditions, medical treatments, or debilitating conditions for which the medical use of cannabidiol would be medically beneficial under Iowa Code chapter 124E may be submitted to the board pursuant to this rule.

154.65(1) Petition form. Any person or entity may file a petition to add or remove medical conditions, medical treatments or debilitating diseases with the board. A petition is deemed filed when it is received by the medical cannabidiol office. The board must provide the petitioner with a file-stamped copy of the petition if the petitioner provides the board an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

BEFORE THE MEDICAL CANNABIDIOL BOARD

<table>
<thead>
<tr>
<th>Petition by (Name of Petitioner) for the (addition or removal) of (medical conditions, medical treatments or debilitating diseases) to the list of debilitating medical conditions for which the medical use of cannabidiol would be medically beneficial.</th>
</tr>
</thead>
</table>

PETITION FOR (ADDITION or REMOVAL)

The petition must provide the following information:

a. A statement of the specific medical condition, medical treatment or debilitating disease the petitioner is seeking to add to or remove from the list of debilitating medical conditions for which the medical use of cannabidiol would be medically beneficial.

b. A brief summary of the petitioner’s arguments in support of the action urged in the petition.

c. A brief summary of any data or scientific evidence supporting the action urged in the petition.

d. A list of reference material supporting the petition.

e. A list of subject matter experts who are willing to testify in support of the petition. The list of subject matter experts must contain names, credentials (if applicable), email addresses, telephone numbers, and mailing addresses.

f. 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.

154.65(2) Signature and address. The petition must be dated and signed by the petitioner or the petitioner’s representative. It must also include the name, mailing address, telephone number and email address of the petitioner and petitioner’s representative, and a statement indicating the person to whom communications concerning the petition should be directed.

154.65(3) Denial for format. The board may deny a petition because it does not substantially conform to the required form.

154.65(4) Briefs. The petitioner may attach a brief to the petition in support of the action urged in the petition. The board may request a brief from the petitioner or from any other person or entity concerning the substance of the petition.
154.65(5) Inquiries. Inquiries concerning the status of a petition may be made to the Office of Medical Cannabidiol, Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075.

154.65(6) Additional information. The board may request the petitioner to submit additional information concerning the petition. The board may also solicit comments from any person on the substance of the petition. Comments on the substance of the petition may be submitted to the board by any person.

154.65(7) Presentation to the board. The board may request or allow the petitioner to make an oral presentation of the contents of a petition at a board meeting following submission of the petition.

154.65(8) Board response. Within six months after the filing of the petition, or within any longer period agreed to by the petitioner, the board must, in writing, either deny the petition and notify the petitioner of the board’s action and the reasons therefore, or grant the petition and notify the petitioner that the board has recommended addition or removal of the medical condition, medical treatment, or debilitating disease to the board of medicine. A petitioner shall be deemed notified of the denial or recommendation on the date when the board mails the required notification to the petitioner.

154.65(9) Denials. 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 3606C, IAB 1/31/18, effective 3/7/18]

641—154.66 to 154.68 Reserved.

LABORATORY TESTING

641—154.69(124E) Requirements of the department.

154.69(1) Laboratory testing requirements and acceptance criteria. The department shall work with manufacturers and laboratories to create and maintain a document describing required sampling methodology, acceptance criteria, stability-testing procedures, and other guidance for manufacturers and laboratories on testing procedures. The department shall provide manufacturers and laboratories no less than 14 days in which to comment on proposed revisions to the document, and the department shall provide no less than 30 days’ notice before a revision takes effect. The document shall:

a. Describe the minimum number of sample units and reserve samples required for testing by the laboratory;

b. Describe an option for manufacturers to reduce the amount of testing conducted by allowing compositing of sample units or other techniques that reduce the number of tests required without compromising the safety of the products once a manufacturer has satisfactorily completed a control study for a specific extraction or production process;

c. Describe the minimum requirements for sample size and testing intervals for stability testing;

d. Be available on the department’s website (www.idph.iowa.gov).

154.69(2) Review and approval of manufacturer sampling protocols. The department shall have up to two weeks to review and approve or request revisions to a manufacturer’s sampling protocols required pursuant to subrules 154.26(2) and 154.26(3).

154.69(3) Review and approval of manufacturer stability-testing procedures. The department shall have up to two weeks to review and approve or request revisions to a manufacturer’s stability-testing procedures required pursuant to subrule 154.26(4).

154.69(4) Establish a laboratory review committee. The department shall establish a laboratory review committee to assist with the review of applications by laboratories and the establishment of accepted laboratory testing standards and practices.

[ARC 4078C, IAB 10/10/18, effective 11/14/18; ARC 4489C, IAB 6/5/19, effective 7/10/19; see Delay note at end of chapter]

641—154.70(124E) Requirements of a laboratory.
154.70(1) Minimum testing requirements. A laboratory shall establish and implement test methods and corresponding standard operating procedures for the analyses of cannabinoids, residual solvents and processing chemicals, pesticides, microbiological impurities, and metals.

154.70(2) Additional tests upon request. A laboratory shall establish and implement test methods and corresponding standard operating procedures for other analyses as requested by the department.

154.70(3) Level of quantitation. A laboratory shall be able to demonstrate that its LOQ is below any action level established by the department.

154.70(4) Inventory tracking.
   a. A laboratory shall use the department’s secure sales and inventory tracking system, if available, or a manifest system to record the receipt of medical cannabis goods from a manufacturer for testing.
   b. A laboratory shall use the department’s secure sales and inventory tracking system, if available, or a manifest system to record the return of medical cannabis goods or waste to a manufacturer.

154.70(5) Hazardous waste disposal.
   a. A laboratory shall discard hazardous waste, including hazardous waste containing medical cannabis goods, in accordance with federal and state hazardous waste laws.
   b. A laboratory shall document the waste disposal procedures followed for each sample.

[ARC 3836C, IAB 6/6/18, effective 7/11/18]

641—154.71(124E) Requirements of a manufacturer.

154.71(1) Assuming costs. A manufacturer shall assume the costs for all laboratory testing requested by the department or laboratory for medical cannabis goods produced by the manufacturer.

154.71(2) Sample waste retrieval. A manufacturer shall retrieve analyzed samples and waste containing medical cannabis goods from the laboratory at a duration and frequency approved by the department.

154.71(3) Obtaining approval for sampling protocols. A manufacturer shall obtain approval from the department for the manufacturer’s sampling protocols pursuant to subrule 154.26(2) prior to submitting samples for laboratory testing related to content and contamination.

154.71(4) Obtaining approval for stability-testing procedures. A manufacturer shall obtain approval from the department for the manufacturer’s stability-testing procedures pursuant to subrule 154.26(4) prior to submitting samples for laboratory testing related to stability testing and product-expiration-date studies.

[ARC 3836C, IAB 6/6/18, effective 7/11/18; ARC 4078C, IAB 10/10/18, effective 11/14/18]

641—154.72(124E) Content testing.

154.72(1) Cannabinoids.
   a. For each unique lot of medical cannabidiol, and if asked to do so by a requester for other medical cannabis goods, a laboratory shall, at minimum, test for and report measurements for the following cannabinoid analytes:
      (1) THC;
      (2) THCA;
      (3) CBD; and
      (4) CBDA.
   b. A laboratory shall report that the primary sample passed or failed THC potency testing according to guidance in the laboratory testing requirements and acceptance criteria document described in subrule 154.69(1).
   c. A laboratory shall report that the primary sample passed or failed CBD potency testing according to guidance in the laboratory testing requirements and acceptance criteria document described in subrule 154.69(1).
   d. For each cannabinoid analyte test, a laboratory shall issue a certificate of analysis that contains the following:
      (1) Concentrations of cannabinoid analytes in mg/ml for liquids and mg/g for solids, or other measures approved by the department.
(2) Whether the primary sample passed or failed the test in accordance with paragraph 154.72(1)“b.”

   e. The laboratory may test for and provide test results for additional cannabinoid analytes if asked to do so by a requester.

154.72(2) Contaminants—residual solvents and processing chemicals.

a. For each unique lot of medical cannabidiol, and if asked to do so by a requester for other medical cannabis goods, a laboratory shall analyze primary samples for residual solvents and processing chemicals.

b. The department shall provide a list of residual solvents and processing chemicals for which primary samples are to be tested with corresponding action levels on the department’s website (www.idph.iowa.gov).

c. For each residual solvent or processing chemical for which a primary sample is tested, a laboratory shall report that the primary sample passed the testing if the concentration of residual solvent or processing chemical is at or below the action level approved by the department.

d. For each residual solvent or processing chemical for which a laboratory tests, the laboratory shall report that the primary sample failed the testing if the concentration of residual solvent or processing chemical is above the action level approved by the department.

e. If a laboratory is using mass spectrometry instrumentation to analyze primary samples for residual solvents and processing chemicals and the laboratory determines that a primary sample contains residual solvent or processing chemical analytes that are not included in the department-approved list of required tests, the laboratory shall attempt to achieve tentative identification and semiquantitative results of the residual solvent or processing chemical analytes.

f. The laboratory may test for and provide test results for additional residual solvents or processing chemicals if asked to do so by a requester.

g. For each primary sample tested, a laboratory shall issue a certificate of analysis that contains the following:

(1) The name and concentration of each residual solvent or processing chemical for which the primary sample was tested.

   1. The concentrations shall be listed in parts per million (ppm) or other units as determined by the department.

   2. The laboratory shall report a result of “detected but not quantified” for any target residual solvent or processing chemical that falls below the LOQ, has a signal-to-noise ratio of greater than 3:1, and meets identification criteria.

(2) Whether the primary sample passed or failed the test in accordance with paragraphs 154.72(2)“c” and 154.72(2)“d.”

(3) The names and amounts of any additional residual solvents and processing chemicals identified by the laboratory.

h. If the primary sample fails testing for residual solvents and processing chemicals, the lot fails laboratory testing.

i. When a laboratory identifies additional residual solvents and processing chemicals in a primary sample, the laboratory shall:

   1. Notify the department of the additional residual solvents and processing chemicals and the amounts detected.

   2. Refrain from issuing a final certificate of analysis to a manufacturer until given approval to do so by the department.

154.72(3) Contaminants—pesticides.

a. For each unique lot of medical cannabidiol, and if asked to do so by a requester for other medical cannabis goods, the laboratory shall analyze primary samples for pesticides.

b. The department shall provide a list of pesticides for which primary samples are to be tested with corresponding action levels on the department’s website (www.idph.iowa.gov).
c. For each pesticide for which a laboratory tests, the laboratory shall report that the primary sample passed the testing if the concentration of pesticide is at or below the action level approved by the department.

d. For each pesticide for which a laboratory tests, the laboratory shall report that the primary sample failed the testing if the concentration of pesticide is above the action level approved by the department.

e. If a laboratory is using mass spectrometry instrumentation to analyze primary samples for pesticides and the laboratory determines that a primary sample contains pesticide analytes that are not included in the department-approved list of required tests, the laboratory shall attempt to achieve tentative identification and semiquantitative results of the pesticide analytes.

f. The laboratory may test for and provide test results for additional pesticides if asked to do so by a requester.

g. For each primary sample tested, a laboratory shall issue a certificate of analysis that contains the following:

1. The name and concentration of each pesticide for which the primary sample was tested.

2. The laboratory shall report a result of “detected but not quantified” for any pesticide that falls below the LOQ, has a signal-to-noise ratio of greater than 3:1, and meets identification criteria.

3. The laboratory shall issue a certificate of analysis that contains the following:

a. For each unique lot of medical cannabinoid, and if asked to do so by a requester for other medical cannabis goods, the laboratory shall analyze primary samples for metals.

b. The department shall provide a list of metals for which primary samples are to be tested with corresponding action levels on the department’s website (idph.iowa.gov).

c. For each metal for which a laboratory tests, the laboratory shall report that the primary sample passed the testing if the concentration of metal is at or below the action level approved by the department.

d. For each metal for which a laboratory tests, the laboratory shall report that the primary sample failed the testing if the concentration of metal is above the action level approved by the department.

e. If a laboratory is using mass spectrometry instrumentation to analyze primary samples for metals and the laboratory determines that a primary sample contains metal analytes that are not included in the department-approved list of required tests, the laboratory shall attempt to achieve tentative identification and semiquantitative results of the metal analytes.

f. The laboratory may test for and provide test results for additional metals if asked to do so by a requester.

g. For each primary sample tested, a laboratory shall issue a certificate of analysis that contains the following:

1. The name and concentration of each metal for which the primary sample was tested.

2. The laboratory shall report a result of “detected but not quantified” for any metal that falls below the LOQ, has a signal-to-noise ratio of greater than 3:1, and meets identification criteria.
If the primary sample fails testing for metals, the lot fails laboratory testing.  
When a laboratory identifies additional metals in a primary sample, the laboratory shall:

(1) Notify the department of the additional metals and the amounts detected.
(2) Refrain from issuing a final certificate of analysis to a manufacturer until given approval to do so by the department.

154.72(5) Contaminants—microbiological impurities.

(a) For each unique lot of medical cannabidiol, and if asked to do so by a requester for other medical cannabis goods, the laboratory shall analyze primary samples for microbiological impurities.
(b) The department shall provide a list of microbiological impurities for which primary samples are to be tested on the department’s website (www.idph.iowa.gov).
(c) For each microbiological impurity for which a laboratory tests, the laboratory shall report that the primary sample passed the testing if the microbiological impurity is not detected in 1 gram of matrix or as approved by the department. A primary sample may be reported as passed if a screening procedure yields a negative result or if a presumptively positive result is not found to be positive on the confirmatory procedure.
(d) For each microbiological impurity for which a laboratory tests, the laboratory shall report that the primary sample failed the testing if the microbiological impurity is detected in 1 gram of matrix or as approved by the department. Confirmatory procedures shall be conducted on all presumptively positive results.
(e) If a laboratory is using methods to test primary samples for microbiological impurities and the laboratory determines that a primary sample contains microbiological impurities that are not included in the department-approved list of required tests, the laboratory shall attempt to achieve tentative identification of the biological impurity.
(f) The laboratory may test for and provide test results for additional microbiological impurities if asked to do so by a requester.
(g) For each primary sample tested, a laboratory shall issue a certificate of analysis that contains the following:
(1) The name of each microbiological impurity for which the primary sample was tested.
(2) Whether the primary sample passed or failed the test in accordance with paragraphs 154.72(5)“c” and 154.72(5)“d.”
(3) The names of any additional microbiological impurities identified by the laboratory.
(h) If the primary sample fails testing for microbiological impurities, the lot fails laboratory testing.
(i) When a laboratory identifies additional microbiological impurities in a primary sample, the laboratory shall:
(1) Notify the department of the additional microbiological impurities detected.
(2) Refrain from issuing a final certificate of analysis to a manufacturer until given approval to do so by the department.

154.72(6) Additional tests. The laboratory may perform additional tests if asked to do so by a requester.

[ARC 3836C, IAB 6/6/18, effective 7/11/18; ARC 4078C, IAB 10/10/18, effective 11/14/18; ARC 4489C, IAB 6/5/19, effective 7/10/19; see Delay note at end of chapter]

641—154.73(124E) Reporting requirements.

154.73(1) Reporting test results. The laboratory shall generate a certificate of analysis for each primary sample that it tests and make the certificate of analysis available to the manufacturer who ordered the tests and the department through the department’s secure sales and inventory tracking system, if available, or another laboratory information management system.

154.73(2) Tentatively identified analytes. A laboratory shall report on the certificate of analysis any tentatively identified analytes detected during the analysis of the primary sample. When a laboratory identifies additional analytes in a primary sample, the laboratory shall:
(a) Notify the department of the additional analytes detected.
b. Refrain from issuing a final certificate of analysis to a manufacturer until given approval to do
so by the department.

154.73(3) Additional reporting requirements.

a. In addition to the requirements described in rule 641—154.72(124E), the certificate of analysis
shall contain, at a minimum, the following information:
(1) All requirements of Standard ISO/IEC 17025;
(2) Date of primary sample collection;
(3) Date the primary sample was received by the laboratory;
(4) Date of each analysis;
(5) The LOQ and action level for each analyte, as applicable;
(6) Whether the primary sample and lot passed or failed laboratory testing; and
(7) A signature by the laboratory quality officer and the date the certificate of analysis was validated
as being accurate by the laboratory quality officer.

b. Any test result that is not covered under the laboratory’s ISO/IEC 17025 scope of accreditation
shall be clearly identified on the certificate of analysis.

c. Measurements below a method’s limit of detection shall be reported as “<” (less than) or “not
detected” and reference the reportable limit. The reporting of zero concentration is not permitted.

d. Measurements ≥ LOD but < LOQ shall be reported as “detected but not quantified.”

e. The number of significant figures reported shall reflect the precision of the analysis.

[ARC 3836C; IAB 6/6/18, effective 7/11/18]

641—154.74(124E) Record-keeping requirements.

154.74(1) Data package. A laboratory shall create a data package for each analytical batch of
primary samples that the laboratory analyzes. The data package shall contain at minimum the following
information:

a. The name and address of the laboratory that performed the analytical procedures;

b. The names, functions, and signatures (electronic or handwritten) of the laboratory personnel that
performed the primary sample preparation, analyzed the primary samples, and reviewed and approved
the data;

c. All primary sample and analytical batch quality control sample results;

d. Raw data for each primary sample analyzed;

e. Instrument raw data, if any was produced;

f. Instrument test method with parameters;

g. Instrument tune report, if one was created;

h. All instrument standard calibration data;

i. Test-method worksheets or forms used for primary sample identification, characterization, and
calculations, including chromatograms, sample-preparation worksheets, and final datasheets;

j. The quality control report with worksheets, forms, or copies of laboratory notebook pages
containing pertinent information related to the identification and traceability of all reagents, reference
materials, and standards used for analysis;

k. The analytical batch sample sequence;

l. The field sample log; and

m. The chain-of-custody form.

154.74(2) Review of data package. After the laboratory has compiled a data package, another
individual at the laboratory shall independently review the data package. The reviewer shall:

a. Assess the analytical results for technical correctness and completeness;

b. Verify that the results of each analysis carried out by the laboratory are reported accurately,
clearly, unambiguously, and objectively;

c. Verify that the measurements can be traced back; and

d. Approve the measurement results by signing and dating the data package prior to release of the
certificate of analysis by the laboratory.
154.74(3) Data package record retention. The entire data package shall be stored by a laboratory for a minimum of five years and shall be made available upon request by the department or the requester of the laboratory testing.

154.74(4) Other records. A laboratory shall maintain all documents, forms, records, and standard operating procedures associated with the testing of medical cannabis goods.

a. A laboratory shall maintain analytical testing laboratory records in such a manner that the analyst, the date the analysis was performed, the approver of the certificate of analysis, the reviewer and approver of the data package, the test method, and the materials that were used can be determined by the department.

b. Records shall be stored in such a way that the data may be readily retrieved when requested by the department.

c. All testing laboratory records shall be kept for a minimum of five years, unless otherwise noted in these rules.

d. The department shall be allowed access to all electronic data, including standards records, calibration records, extraction logs, and laboratory notebooks.

e. A laboratory shall keep and make available to the department the following records related to the testing of medical cannabis goods:

1. Personnel qualification, training, and competency documentation, including but not limited to résumés, training records, continuing education records, analytical proficiency testing records, and demonstration of competency records for laboratory work. These records shall be kept current.

2. Method verification and validation records, including method modification records, method detection limit and quantitation limit determination records, ongoing verification records such as proficiency test records and reference material analysis records.

3. Quality control and quality assurance records, including the laboratory’s quality assurance manual and control charts with control limits.

4. Chain-of-custody records, including chain-of-custody forms, field sample logs, sample-receipt records, sample-description records, sample-rejection records, laboratory information management system records, sample-storage records, sample-retention records, and disposal records.

5. Purchasing and supply records, equipment-services records, and other equipment records, including purchase requisition records, packing slips, supplier records, and certificates of analysis.

6. Laboratory equipment installation records, maintenance records, and calibration records. These records shall include the date and name of the person performing the installation of, calibration of, or maintenance on the equipment, with a description of the work performed, maintenance logs, pipette calibration records, balance calibration records, working and reference mass calibration records, and daily verification-of-calibration records.

7. Customer service records, including customer contracts, customer requests, certificates of analysis, customer transactions, customer feedback, records related to the handling of complaints and nonconformities, and corrective action pertaining to complaints.

8. Nonconforming work and corrective action records, including corrective action, nonconformance, nonconformities resolved by correction, customer notification of nonconformities, internal investigations, implementation of corrective action, and resumption-of-work records.

9. Internal-audit and external-audit records, including audit checklists, standard operating procedures, and audit observation and findings reports. These records shall include the date and name of the person performing the audit.

10. Management review records, including technical data review reports and final management-review reports. These records shall include the review date and the name of the reviewer.

11. Laboratory data reports, data review, and data approval records, including instrument and equipment identification records, records with unique sample identifiers, analysts’ laboratory notebooks and logbooks, traceability records, test-method worksheets and forms, instrumentation-calibration data, and test-method raw data. These records shall include the analysis date and the name of the analyst.
(12) Proficiency testing records, including the proficiency test schedule, proficiency tests, data-review records, data-reporting records, nonconforming work and corrective actions, and quality control and quality assurance records related to proficiency testing.

(13) Electronic data, backed-up data, records regarding the protection of data, including unprocessed instrument output data files and processed quantitation output files, electronic data protocols and records, and authorized personnel records.

(14) Security data, including laboratory-security records and laboratory-access records, surveillance-equipment records, and security-equipment records. These records shall be stored for at least one year.

(15) Traceability, raw data, standards records, calibration records, extraction logs, reference materials records, analysts’ laboratory notebooks and logbooks, supplier records, and certificates of analysis, and all other data-related records.

(16) Laboratory contamination and cleaning records, including autoclave records, acid-wash logs and records, and general laboratory-safety and chemical-hygiene protocols.

[ARC 3836C, IAB 6/6/18, effective 7/11/18]

641—154.75(124E) Quality control. The laboratory shall have quality control protocols that include the following elements:

154.75(1) Quality control samples required.

a. The laboratory shall run quality control samples with every analytical batch of samples for chemical and microbiological analysis.

b. For microbiological analysis, the laboratory shall develop procedures for quality control requirements for each analytical batch of samples.

c. The laboratory shall analyze the quality control samples in exactly the same manner as the test samples to validate the laboratory testing results.

154.75(2) Types of quality control samples. At a minimum, a laboratory shall have the following quality control samples as part of every analytical batch tested for chemical analytes:

a. Negative control (method blank). A laboratory shall prepare and run at least one method blank sample with an analytical batch of 10 to 20 samples along with and under the same conditions, including all sample preparation steps, as the other samples in the analytical batch, to demonstrate that the analytical process did not introduce contamination.

b. Positive control (laboratory control sample). A laboratory shall prepare and run at least one laboratory control sample with an analytical batch of 10 to 20 samples along with and under the same conditions, including all sample preparation steps, as the other samples in the analytical batch.

c. Matrix spike sample. A laboratory shall prepare and run one or more matrix spike samples for each analytical batch.

(1) A laboratory shall calculate the percent recovery for quantitative chemical analysis by dividing the sample result by the expected result and multiplying that by 100. All quality control measures shall be assessed and evaluated on an ongoing basis, and quality control acceptance criteria shall be used. When necessary, the department may establish acceptance criteria on the department’s website (www.idph.iowa.gov).

(2) If quality control acceptance criteria are not acceptable, a laboratory shall investigate the cause, correct the problem, and rerun the analytical batch of samples. If the problem persists, the laboratory shall reprepare the samples and run the analysis again, if possible.

d. Field duplicate sample. A laboratory shall prepare and run a duplicate sample as described in the laboratory testing requirements and acceptance criteria document in subrule 154.69(1). The acceptance criterion between the primary sample and the duplicate sample is less than or equal to 20 percent relative percent difference.

154.75(3) Certified reference material for chemical analysis. The laboratory shall use a reference material for each analytical batch in accordance with the following standards:
a. The reference material should be certified and obtained from an outside source, if possible. If a reference material is not available from an outside source, the laboratory shall make its own in-house reference material.

b. Reference material made in-house should be made from a different source of standards than the source from which the calibration standards are made.

c. The test result for the reference material shall fall within the quality control acceptance criteria. If it does not, the laboratory shall document and correct the problem and run the analytical batch again.

154.75(4) Calibration standards. The laboratory shall prepare calibration standards by serially diluting a standard solution to produce working standards used for calibration of an instrument and quantitation of analyses in samples.

154.75(5) Quality control-sample report. A laboratory shall generate a quality control-sample report that includes quality control parameters and measurements, analysis date, and type of matrix.

154.75(6) Limit-of-detection and limit-of-quantitation calculations. For chemical method analysis, a laboratory shall calculate the limit of detection and limit of quantitation using generally accepted methodology.

[ARC 3836C, IAB 6/6/18, effective 7/11/18; ARC 4489C, IAB 6/5/19, effective 7/10/19]

641—154.76(124E) Security requirements. The department may request assistance from the department of public safety in ensuring a laboratory meets the security requirements in this rule.

154.76(1) Security policy requirement. A laboratory shall maintain a security policy to prevent the loss, theft, or diversion of medical cannabis goods and samples. The security policy shall apply to all staff and visitors at a laboratory facility.

154.76(2) Visitor logs. Visitors to a laboratory facility shall sign visitor manifests with name, date, and times of entry and exit, and shall wear badges that are visible at all times and that identify them as visitors.

154.76(3) Restricted access. A laboratory shall use a controlled access system and written manifests to limit entrance to all restricted access areas of its laboratory facility and shall retain a record of all persons who entered the restricted access areas.

a. The controlled access system shall do all of the following:

(1) Limit access to authorized individuals;

(2) Maintain a log of individuals with approved access, including dates of approvals and revocations;

(3) Track times of personnel entry;

(4) Track times of personnel movement between restricted access areas;

(5) Store data for retrieval for a minimum of one year; and

(6) Remain operable in the event of a power failure.

b. Separate written manifests of visitors to restricted areas shall be kept and stored for a minimum of one year if the controlled access system does not include electronic records of visitors to the restricted areas.

c. A laboratory shall promptly, but no later than five business days after receipt of request, submit stored controlled access system data to the department.

154.76(4) Personnel identification system. A laboratory shall use a personnel identification system that controls and monitors individual employee access to restricted access areas within the laboratory facility and that meets the requirements of this subrule and subrule 154.76(2).

a. Requirement for employee identification card. An employee identification card shall contain:

(1) The name of the employee;

(2) The date of issuance;

(3) An alphanumeric identification number that is unique to the employee; and

(4) A photographic image of the employee.

b. A laboratory employee shall keep the identification card visible at all times when the employee is in the laboratory.

c. Upon termination or resignation of an employee, a laboratory shall immediately:
(1) Revoke the employee’s access to the laboratory; and
(2) Obtain and destroy the employee’s identification card, if possible.

154.76(5) Video monitoring and surveillance.

a. Video surveillance system. A laboratory shall operate and maintain in good working order a video surveillance system for its premises that operates 24 hours per day, seven days a week, and visually records all areas where medical cannabis goods are stored or tested.

b. Camera specifications. Cameras shall:

   (1) Capture clear and certain identification of any person entering or exiting a restricted access area containing medical cannabis goods;
   (2) Have the ability to produce a clear, color still photograph live or from a recording;
   (3) Have on all recordings an embedded date-and-time stamp that is synchronized to the recording and does not obscure the picture; and
   (4) Continue to operate during a power outage.

c. Video recording specifications.

   (1) A video recording shall export still images in an industry standard image format, such as .jpg, .bmp, or .gif.
   (2) Exported video shall be archived in a format that ensures authentication and guarantees that the recorded image has not been altered.
   (3) Exported video shall also be saved in an industry standard file format that can be played on a standard computer operating system.
   (4) All recordings shall be erased or destroyed at the end of the retention period and prior to disposal of any storage medium.

d. Additional requirements. A laboratory shall maintain all security system equipment and recordings in a secure location to prevent theft, loss, destruction, corruption, and alterations.

e. Retention. A laboratory shall ensure that 24-hour recordings from all video cameras are:
   (1) Available for viewing by the department upon request;
   (2) Retained for a minimum of 60 days;
   (3) Maintained free of alteration or corruption; and
   (4) Retained longer, as needed, if a manufacturer is given actual notice of a pending criminal, civil, or administrative investigation, or other legal proceeding for which the recording may contain relevant information.

154.76(6) Chain-of-custody policy and procedures. A laboratory shall maintain a current chain-of-custody policy and procedures. The policy should ensure that:

a. Chain of custody is maintained for samples which may have probable forensic evidentiary value; and

b. Annual training is available for individuals who will be involved with testing medical cannabis goods.

154.76(7) Information technology systems security. A laboratory shall maintain information technology systems protection by employing comprehensive security controls that include security firewall protection, antivirus protection, network and desktop password protection, and security patch management procedures.

[ARC 3836C, IAB 6/6/18, effective 7/11/18]

These rules are intended to implement Iowa Code chapter 124E.

[Filed ARC 1640C (Notice ARC 1571C, IAB 8/6/14), IAB 10/1/14, effective 1/30/15]
[Filed Emergency ARC 3150C, IAB 7/5/17, effective 6/13/17]
[Filed ARC 3606C (Notice ARC 3420C, IAB 10/25/17), IAB 1/31/18, effective 3/7/18]
[Filed ARC 3836C (Notice ARC 3707C, IAB 3/28/18), IAB 6/6/18, effective 7/11/18]
[Filed ARC 4078C (Notice ARC 3899C, IAB 7/18/18), IAB 10/10/18, effective 11/14/18]
[Filed ARC 4399C (Notice ARC 4240C, IAB 1/16/19), IAB 4/10/19, effective 5/15/19]
[Filed ARC 4489C (Notice ARC 4363C, IAB 3/27/19), IAB 6/5/19, effective 7/10/19]¹

¹ July 10, 2019, effective date of Items 1, 4, 7, 10, 11, 12, 13, 15, 21, 22, and 24 of ARC 4489C delayed until the adjournment of the 2020 session of the General Assembly by the Administrative Rules Review Committee at its meeting held July 9, 2019.
PHARMACY BOARD[657]

[Prior to 2/10/88, see Pharmacy Examiners, Board of[620], renamed Pharmacy Examiners Board[657]
under the “umbrella” of Public Health Department by 1986 Iowa Acts, ch 1245; renamed by 2007 Iowa Acts, Senate File 74]

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CHAPTER 2
PHARMACIST LICENSES

[Prior to 2/10/88, see Pharmacy Examiners[620] Chs 1, 5]

657—2.1(147,155A) Purpose and scope. The purpose of this chapter is to set the minimum standards and application process for obtaining and maintaining pharmacist licensure in this state. The rules shall apply to pharmacists who seek or hold pharmacist licensure in Iowa.

[ARC 4579C, IAB 7/31/19, effective 9/4/19]

657—2.2(147,155A) Definitions. For the purposes of this chapter, the following definitions shall apply:

“Board” means the board of pharmacy.

“Continuing pharmacy education” or “CPE” means a structured educational activity that is applicable to the practice of pharmacy, that promotes problem solving and critical thinking, and that is designed or intended to support the continuing development of pharmacists to maintain and enhance their competence in the practice of pharmacy.

“Continuing professional development” or “CPD” means a self-directed, ongoing, systematic, and outcomes-focused approach to learning and professional development including active participation in learning activities that assist a pharmacist in developing and maintaining continuing competence in the practice of pharmacy, enhancing the pharmacist’s professional practice, and supporting achievement of the pharmacist’s career goals.

“CPE monitor” means the program administered by NABP to collect and store CPE data for pharmacy professionals.

“NABP” means the National Association of Boards of Pharmacy.

“Renewal period” means the 27-month period commencing April 1 prior to the previous license expiration and ending June 30, the date of current license expiration.

[ARC 4579C, IAB 7/31/19, effective 9/4/19]

657—2.3(147,155A) License and criminal history record check required.

2.3(1) License required. Prior to engaging in the practice of pharmacy in Iowa, a pharmacist shall have an active Iowa pharmacist license pursuant to rule 657—2.4(147,155A), 657—2.8(155A), or 657—2.9(147,155A).

2.3(2) Criminal history record check required. Upon receipt of an initial licensure application pursuant to subrule 2.3(1), the board shall provide a fingerprint packet to the applicant, who shall submit to the board the completed fingerprint packet and a signed waiver form to facilitate a national criminal history background check of the applicant. The cost of the evaluation of the fingerprint packet and the Iowa division of criminal investigation and United States Federal Bureau of Investigation criminal history background checks will be assessed to the applicant.

[ARC 4579C, IAB 7/31/19, effective 9/4/19]

657—2.4(147,155A) Licensure by examination. The board, in conjunction with NABP, shall provide for the administration of pharmacist licensure examinations.

2.4(1) Components. Applicants shall take and pass the following components: the North American Pharmacist Licensure Examination (NAPLEX); the Multistate Pharmacy Jurisprudence Examination (MPJE), Iowa Edition. A total scaled score of no less than 75 is required to pass each examination.

2.4(2) Timeliness. To be eligible for a license by examination, the candidate shall pass all components in Iowa within a period of one year beginning with the date the candidate passed an initial component. A candidate may request waiver or variance from this deadline pursuant to the procedures and requirements of 657—Chapter 34.

2.4(3) Examination results. Examination scores and original license certificates shall be provided as soon after the examinations as possible.

[ARC 4579C, IAB 7/31/19, effective 9/4/19]

657—2.5(155A) Application for examination—requirements. Application for examination shall be on forms provided by the board, and all requested information shall be provided on or with such
application. An applicant shall additionally apply for eligibility to take the NAPLEX and the Multistate Pharmacy Jurisprudence Examination (MPJE), Iowa Edition, at nabp.pharmacy/programs.

2.5(1) Required information. The application for examination shall require that the applicant provide, at a minimum, the following: name; address; telephone number; date of birth; social security number or individual tax identification number (ITIN); name and location of college of pharmacy and date of graduation; one current photograph of a quality at least similar to a passport photograph; and internship experience. If the applicant provides an ITIN in lieu of a social security number, the applicant shall also provide acceptable proof of lawful presence. Each applicant shall also declare the following: history of prior pharmacist licensure examinations and record of offenses including but not limited to charges, convictions, and fines which relate to the profession or that may affect the licensee’s ability to practice pharmacy.

2.5(2) Sworn statement. The application for examination shall be made as a sworn statement before a notary public, and the notary public shall witness the signature of the applicant.

2.5(3) Fee. The nonrefundable fee for examination shall consist of the biennial license fee, a processing fee, and an examination registration fee.

a. The biennial license fee shall be $180, and the processing fee shall be $72. The nonrefundable biennial license fee and processing fee shall be submitted to the board with the application for licensure by examination.

b. The examination registration fee shall be an amount determined by NABP and submitted pursuant to NABP direction at nabp.pharmacy/programs when submitting an application for eligibility to take the NAPLEX; the MPJE, Iowa Edition; or both.

2.5(4) College graduation certification. Each applicant, with the exception of a foreign pharmacy graduate who shall comply with rule 657—2.10(155A), shall furnish a certificate from a recognized college of pharmacy stating that the applicant has successfully graduated from a college of pharmacy with either a bachelor of science degree in pharmacy or a doctor of pharmacy degree. Certification shall be completed by an individual authorized by the college on a form provided by the board. A recognized college of pharmacy is a United States institution that meets the minimum standards of the Accreditation Council for Pharmacy Education and appears on the list of accredited colleges of pharmacy published by the council as of July 1 of each year.

2.5(5) Foreign pharmacy graduates. In addition to the requirements of this rule, except as provided in subrule 2.5(4), an applicant who is a graduate of a school or college of pharmacy located outside the United States that has not been recognized and approved by the board shall obtain certification by the Foreign Pharmacy Graduate Examination Committee (FPGEC) pursuant to rule 657—2.10(155A).

[ARC 3636C, IAB 2/14/18, effective 3/21/18; ARC 4579C, IAB 7/31/19, effective 9/4/19]

657—2.6(155A) Internship requirements. Each applicant, except for an applicant for license transfer, shall furnish to the board evidence certifying completion of satisfactory internship experience. The board will not certify an applicant eligible to take any of the examination components prior to receipt of evidence of satisfactory completion of internship experience. Internship experience shall comply with the requirements in 657—Chapter 4. Internship experience completed in compliance with the requirements in 657—Chapter 4 shall be valid for application for licensure in Iowa by examination or score transfer for a period of three years following graduation from an approved college of pharmacy or as otherwise approved by the board on a case-by-case basis.

[ARC 4579C, IAB 7/31/19, effective 9/4/19]

657—2.7(147) Reexamination applications and fees. A candidate who fails to pass either the NAPLEX or the MPJE, Iowa Edition, once shall be allowed to schedule a time to retake the examination as provided in this rule. To ensure the integrity of the examinations, no waiver or variance of the specified waiting period between reexaminations will be granted.

2.7(1) NAPLEX. A candidate who fails to pass the NAPLEX once shall be allowed to schedule a time to retake the examination no less than 45 days following administration of the failed examination. The candidate may be approved to retake the NAPLEX no more than three times in a 12-month period.
2.7(2) MPJE, Iowa Edition. A candidate who fails to pass the MPJE, Iowa Edition, once shall be allowed to schedule a time to retake the examination no less than 30 days following administration of the failed examination.

2.7(3) Reexamination after two or more attempts. A candidate who fails to pass either examination following a second or subsequent examination may petition the board for permission to take the examination again. Determination of a candidate’s eligibility to take an examination more than two times shall be at the discretion of the board.

2.7(4) Applications and fees. Each applicant for reexamination shall file an application on forms provided by the board. A nonrefundable processing fee of $36 will be charged for each NAPLEX or MPJE, Iowa Edition, reexamination and shall be paid to the board. In addition, the applicant shall complete the NABP application process for reexamination and pay the required fee for reexamination as determined by NABP at nabp.pharmacy/programs.

657—2.8(155A) Licensure by score transfer. The board of pharmacy participates in the NAPLEX score transfer program offered by NABP. This program allows candidates for pharmacist licensure to take the standardized NAPLEX in one state and have the score from that examination transferred to other participant states in which the candidate is seeking licensure. MPJE scores cannot be transferred.

2.8(1) Application for score transfer. To participate in the NABP score transfer program, an applicant shall complete all required application requirements and submit required fees as determined by NABP at nabp.pharmacy/programs.

2.8(2) Requirements and deadline. Applicants for licensure by score transfer shall meet the requirements established in rules 657—2.4(147,155A) through 657—2.6(155A) within 12 months of the date of score transfer.

2.8(3) Fees. In addition to the score transfer fee identified in subrule 2.8(1), fees for licensure pursuant to the NABP score transfer program shall consist of the fees identified in paragraph 2.5(3)“a.”

657—2.9(147,155A) Licensure by license transfer. An applicant for license transfer must be a pharmacist licensed by examination in a state or territory of the United States, and the license by examination upon which the transfer is based must be in good standing at the time of the application and license transfer. All candidates shall take and pass the MPJE, Iowa Edition, as provided in subrule 2.4(1). Any candidate who fails to pass the examination shall be eligible for reexamination as provided in rule 657—2.7(147).

2.9(1) Eligibility. Each applicant for license transfer to this state who obtains the applicant’s original license after January 1, 1980, must have passed the NABP Licensure Examination (NABPLEX), the NAPLEX, or an equivalent examination as determined by NABP.

a. Application for license transfer. Each applicant for license transfer to Iowa shall complete the online application and pay the required fee as determined by NABP at nabp.pharmacy/programs.

b. Foreign pharmacy graduates. If the applicant is a graduate of a school or college of pharmacy located outside the United States that has not been recognized and approved by the board, proof of qualifications shall include certification from the FPGEC pursuant to subrule 2.10(1).

2.9(2) Application requirements. Application to the board shall consist of the application for license transfer that is prepared by NABP and electronically submitted to the board pursuant to the NABP license transfer program. A foreign pharmacy graduate shall submit certification from the FPGEC as provided in subrule 2.10(1).

2.9(3) MPJE required. An applicant shall also successfully pass the MPJE, Iowa Edition, as provided in subrule 2.4(1).

2.9(4) Fees. The nonrefundable fee for license transfer shall consist of the biennial license fee of $180 and a processing fee of $90.
2.9(5) Timeliness. An application for license transfer is valid for 12 months following the date of issuance by NABP. An applicant for license transfer shall complete, within that one-year period, all licensure requirements established by this rule.

[ARC 0504C, IAB 12/12/12, effective 1/16/13; ARC 1031C, IAB 9/18/13, effective 10/23/13; ARC 4579C, IAB 7/31/19, effective 9/4/19]

657—2.10(155A) Foreign pharmacy graduates.

2.10(1) Education equivalency. Any applicant who is a graduate of a school or college of pharmacy located outside the United States that has not been recognized and approved by the board shall be deemed to have satisfied the requirements of Iowa Code section 155A.8, subsection 1, by certification by the FPGECE. Each applicant shall have successfully passed the Foreign Pharmacy Graduate Equivalency Examination (FPGECE) given by the FPGECE established by NABP. The FPGECE is hereby recognized and approved by the board. Each applicant shall also demonstrate proficiency in basic English language skills by passing the Internet Based Test of English as a Foreign Language (TOEFL iBT) given by the FPGECE established by NABP. The TOEFL iBT is hereby recognized and approved by the board. Certification by the FPGECE shall be evidence of the applicant’s successfully passing the FPGECE and TOEFL iBT, and certification is a prerequisite to taking the licensure examinations required in subrule 2.4(1).

2.10(2) Internship. A foreign pharmacy graduate applicant shall also be required to obtain internship experience in one or more board-licensed pharmacies as provided in rule 657—4.7(155A). Internship requirements shall be, in all other aspects, meet the requirements established in 657—Chapter 4.

[ARC 4579C, IAB 7/31/19, effective 9/4/19]

657—2.11(147.155A) License expiration and renewal. A license to practice pharmacy shall expire on the second thirtieth day of June following the date of issuance of the license, with the exception that a new pharmacist license issued between April 1 and June 29 shall expire on the third thirtieth day of June following the date of issuance. The license renewal certificate shall be issued upon completion of the renewal application and payment of a nonrefundable fee of $180.

2.11(1) Late renewal penalty. Failure to renew the license before July 1 following expiration shall require payment of the nonrefundable renewal fee and a nonrefundable penalty fee of $180. Failure to renew the license before August 1 following expiration shall require payment of the nonrefundable renewal fee and a nonrefundable penalty fee of $270. Failure to renew the license before September 1 following expiration shall require payment of the nonrefundable renewal fee and a nonrefundable penalty fee of $360. Failure to renew the license before October 1 following expiration may require an appearance before the board and shall require payment of a nonrefundable reactivation fee of $630. The provisions of Iowa Code section 147.11 shall apply to a license that is not renewed within five months of the expiration date.

2.11(2) Delinquent license. If a license is not renewed before its expiration date, the license is delinquent and the licensee may not practice pharmacy in the state of Iowa until the licensee reactivates the delinquent license. Reactivation of a delinquent license shall include submission of a completed application and appropriate nonrefundable fees and may include requirements relating to the reactivation of an inactive license pursuant to subrule 2.13(2). A pharmacist who continues to practice pharmacy in Iowa without a current license may be subject to disciplinary sanctions pursuant to the provisions of 657—subrule 36.6(22).

[ARC 0504C, IAB 12/12/12, effective 1/16/13; ARC 4579C, IAB 7/31/19, effective 9/4/19]

657—2.12(272C) Continuing education requirements. Pharmacists shall complete continuing education for license renewal pursuant to the requirements of this rule, except as provided in subrule 2.12(6) or rule 657—2.17(272C). Nothing in these rules precludes the board from requiring an applicant for license renewal or reactivation to submit to a relicensure examination.

2.12(1) Continuing pharmacy education (CPE) required. A pharmacist shall complete no less than 30 hours of CPE during each renewal period except as provided in subrule 2.12(6) or rule 657—2.17(272C).
a. A pharmacist who fails to complete the required CPE hours within the renewal period shall be required to complete one and one-half times the number of delinquent CPE hours prior to reactivation of the license.

b. CPE hours that are used to satisfy the CPE requirement for one renewal period shall not be used to satisfy the requirement for a subsequent renewal period.

c. Failure to receive a license renewal application or notice of license renewal shall not relieve the pharmacist of the responsibility of meeting CPE requirements.

2.12(2) CPE activity completion.

a. ACPE provider activity. CPE activities that carry the seal of an Accreditation Council for Pharmacy Education (ACPE)-accredited provider will automatically qualify for CPE credit. Successful completion and record of CPE activities in CPE Monitor is mandated in order for a pharmacist to receive credit for ACPE-accredited provider CPE activities.

b. Non-ACPE provider activity. A maximum of 13 CPE hours of the total 30 CPE hours required pursuant to subrule 2.12(4) may be obtained through completion of non-ACPE provider activities if such activities are provided by an accredited health-professional continuing education provider, such as a continuing medical education (CME) provider, and if the activity content directly relates to the pharmacist’s professional practice. Non-ACPE provider activity completion shall be recorded, evaluated, and reported pursuant to the provisions of rule 657—2.17(272C) regarding continuing professional development.

(1) The pharmacist is responsible for ensuring that the activity content directly relates to the pharmacist’s professional practice.

(2) If one or more non-ACPE provider activities are intended to fulfill the requirement in paragraph 2.12(4) “c,” the pharmacist is responsible for ensuring the activity content relates to patient or medication safety.

(3) If the non-ACPE provider is not able to transmit the activity record to CPE Monitor, the provider shall provide to the pharmacist a statement of credit that indicates the pharmacist’s participation in and successful completion of the continuing education activity. The statement of credit shall include all information identified in subrule 2.12(3), except for the pharmacist’s CPE Monitor e-profile identification number.

2.12(3) CPE activity record of credit. An ACPE-accredited provider will be required to transmit to CPE Monitor information regarding an individual pharmacist’s participation in and successful completion of a CPE activity. The record shall be accessible to the board and shall include the following information:

a. Pharmacist’s full name and CPE Monitor e-profile identification number.

b. Number of contact hours or CEUs awarded for activity completion.

c. Date of live activity or date of completion of home study activity.

d. Name of accredited provider.

e. Activity title and universal activity number.

2.12(4) CPE activity topics. Each pharmacist is required to obtain CPE by completing activities in the topics specified in this subrule.

a. Drug therapy. A minimum of 15 CPE hours of the required 30 CPE hours shall be in ACPE-accredited provider activities dealing with drug therapy. Activities qualifying for the drug therapy requirement will include the ACPE topic designator “01” or “02” followed by the letter “P” at the end of the universal activity number.

b. Pharmacy law. A minimum of 2 CPE hours of the required 30 CPE hours shall be in ACPE-accredited provider activities dealing with pharmacy law. Activities qualifying for the pharmacy law requirement will include the ACPE topic designator “03” followed by the letter “P” at the end of the universal activity number.

c. Patient or medication safety. A minimum of 2 CPE hours of the required 30 CPE hours shall be in activities dealing with patient or medication safety. Activities completed to fulfill this requirement may be ACPE-accredited provider activities, in which case the universal activity number will end with the
ACPE topic designator “05” followed by the letter “P.” A pharmacist may complete non-ACPE provider activities as provided in paragraph 2.12(2) “b” to fulfill this topic requirement.

   d. Immunization. If the pharmacist is engaged in the administration of immunizations during the renewal period, a minimum of 1 CPE hour of the required 30 CPE hours shall be in ACPE-accredited provider activities dealing with immunization or vaccine administration. Activities qualifying for the immunization requirement will include the ACPE topic designator of “06” followed by the letter “P” at the end of the universal activity number.

   2.12(5) Reporting CPE credits.
   a. A pharmacist shall provide or report to the board, in the format specified on or with the pharmacist license renewal application, attestation that the CPE requirements have been met.

   b. The board may require a pharmacist to submit activity statements of credit or other documented evidence of successful completion of the activities reported as fulfilling the CPE requirements.

   2.12(6) Exemptions and waivers to CPE requirements.
   a. Credit for health-related graduate studies. A pharmacist who is continuing formal education in a health-related graduate program, including participation in a pharmacy residency program, may be granted credit for health-related learning during the period of such enrollment or participation. As an alternative to requesting credit for health-related learning, the pharmacist may complete a CPD portfolio pursuant to rule 657—2.17(272C).

   (1) An applicant for credit for health-related learning shall petition the board, as soon as possible following enrollment in the qualifying graduate program or commencement of the pharmacy residency program and prior to completion of the qualifying program, on forms provided by the board.

   (2) At the discretion of the board, credit granted for health-related learning during part-time or short-term enrollment in a health-related graduate program may be prorated for the actual period of such enrollment.

   b. Exemption for new license holders licensed by examination. After the initial license is issued by examination, the licensee is exempt from meeting CPE requirements for the first license renewal. However, if the licensee qualifies as a mandatory abuse reporter, the licensee shall not be exempt from mandatory training for identifying and reporting abuse pursuant to rule 657—2.16(235B,272C).

   c. Waiver from CPE requirements due to physical disability or illness. The board may, in individual cases involving physical disability or illness, grant a waiver pursuant to 657—Chapter 34 of the minimum CPE requirements or an extension of time within which to fulfill the same or make the required reports. The board may grant a waiver of the minimum CPE requirements for physical disability or illness for any period of time not to exceed one renewal period. In the event that the physical disability or illness upon which a waiver has been granted continues beyond the period of the waiver, the licensee must reapply for an extension of the waiver. The board may, as a condition of any waiver granted, require the licensee to make up all or any portion of the waived CPE requirements by any method prescribed by the board. A waiver request pursuant to this paragraph and 657—Chapter 34 shall be signed by the licensee and the licensee’s physician.

   d. Active military duty. A licensee shall be deemed compliant with the CPE requirements of this rule during periods that the licensee serves honorably on active duty in the military services.

   e. Nonresident. A licensee who is not actively practicing in Iowa, is a resident of another state, and holds an active pharmacist license in the licensee’s home state during the renewal period shall be deemed compliant with the CPE requirements of this rule.

   [ARC 8672B, IAB 4/7/10, effective 5/12/10; ARC 9406B, IAB 3/9/11, effective 4/13/11; ARC 9782B, IAB 10/5/11, effective 11/9/11; ARC 0595C, IAB 2/6/13, effective 3/13/13; ARC 4579C, IAB 7/31/19, effective 9/4/19]

657—2.13(272C) Active and inactive license status.

   2.13(1) Active license. Active license status applies to a pharmacist who has submitted the renewal application and nonrefundable fee and has met Iowa requirements for CPE or has completed a CPD portfolio pursuant to rule 657—2.17(272C). Active license status also applies to a pharmacist who has submitted the renewal application and fee and who is a resident of another state, is licensed to practice pharmacy in that state, and has met the continuing education requirements of that state. A pharmacist
who meets the continuing education requirements of another state shall provide documentation on the renewal application of the pharmacist’s license status in that state.

2.13(2) **Inactive license.** Failure of a pharmacist to comply with the CPE or CPD requirements during the renewal period shall result in the issuance of a renewal card marked “inactive” upon submission of the renewal application and nonrefundable fee. Reactivation of an inactive pharmacist license shall be accomplished by the appropriate method described below. Internship, in each instance where internship is mentioned below, shall be in a pharmacy approved by the board. The pharmacist may be required to obtain a pharmacist-intern registration, including payment of the appropriate nonrefundable registration fee, and be issued an intern registration certificate.

a. An inactive pharmacist who wishes to become active and who has been actively practicing pharmacy during the last five years in any state or states which required continuing education during that five-year period shall submit proof of continued licensure in good standing in the state or states of such practice.

b. An inactive pharmacist who wishes to become active and who has been actively practicing pharmacy during the last five years in a state which does not require continuing education shall submit proof of continued licensure in good standing in the state or states of such practice. The pharmacist shall also complete one of the following options:

1. Take and successfully pass the MPJE, Iowa Edition, as provided in subrule 2.4(1);
2. Complete 160 hours of internship for each year the pharmacist was on inactive status (not to exceed 1,000 hours);
3. Obtain one and one-half times the number of CPE credits required under subrule 2.12(1) for each renewal period the pharmacist was inactive; or
4. Complete a CPD portfolio pursuant to rule 657—2.17(272C) identifying a minimum of 45 learning outcomes for each renewal period the pharmacist was inactive.

c. An inactive pharmacist who wishes to become active and who has not been actively practicing pharmacy during the past five years, and whose license has been inactive for not more than five years, shall complete one of the following options:

1. Successfully pass all components of the licensure examination as required in subrule 2.4(1);
2. Complete 160 hours of internship for each year the pharmacist was on inactive status;
3. Obtain one and one-half times the number of CPE credits required under subrule 2.12(1) for each renewal period the pharmacist was inactive; or
4. Complete a CPD portfolio pursuant to rule 657—2.17(272C) identifying a minimum of 45 learning outcomes for each renewal period the pharmacist was inactive.

d. An inactive pharmacist who wishes to become active and who has not been actively practicing pharmacy for more than five years shall petition the board for reactivation of the license to practice pharmacy under one or more of the following options:

1. Successfully pass all components of the licensure examination as required in subrule 2.4(1);
2. Complete 160 hours of internship for each year the pharmacist was on inactive status (not to exceed 1,000 hours);
3. Obtain one and one-half times the number of CPE credits required under subrule 2.12(1) for each renewal period the pharmacist was inactive; or
4. Complete a CPD portfolio pursuant to rule 657—2.17(272C) identifying a minimum of 45 learning outcomes for each renewal period the pharmacist was inactive.

[ARC 0595C, IAB 2/6/13; effective 3/13/13; ARC 4579C, IAB 7/31/19, effective 9/4/19]

657—2.14(147,155A) **Fees for additional license certificates and verification.**

2.14(1) Only original license certificates issued by the board for licensed pharmacists are valid. Additional original license certificates for licensed pharmacists may be obtained from the board for a prepaid nonrefundable fee of $20 each. The fee shall be considered a repayment receipt as defined in Iowa Code section 8.2.
2.14(2) The board may require the submission of a nonrefundable fee of $15 for written license verification.
[ARC 4579C, IAB 7/31/19, effective 9/4/19]

657—2.15(155A) Notifications to the board.

2.15(1) Reporting licensee changes. A licensee shall report to the board within ten days a change of the licensee’s name, address, email address, or pharmacy employment. Except for a change in name, an update to the licensee’s personal online profile through the board’s online database shall satisfy this subrule.

2.15(2) Reporting criminal convictions and pleas. A licensee who has been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime, other than a minor traffic offense, shall report such conviction or plea to the board within 30 days of adjudication.

2.15(3) Reporting of disciplinary action. A licensee who has been the subject of disciplinary action in another state, to include but not be limited to citations, reprimands, fines, license restrictions, probation, or license surrender, suspension, or revocation, shall report such action to the board within 30 days of adjudication.
[ARC 4579C, IAB 7/31/19, effective 9/4/19]

657—2.16(235B,272C) Mandatory training for identifying and reporting abuse. “Mandatory training for identifying and reporting abuse” means training on identifying and reporting child abuse or dependent adult abuse required of a pharmacist who qualifies as a mandatory abuse reporter under Iowa Code section 232.69 or 235B.16. A licensed pharmacist shall be responsible for determining whether or not, by virtue of the pharmacist’s practice or employment, the pharmacist qualifies as a mandatory abuse reporter under either or both of these sections.

2.16(1) Training required. A licensed pharmacist who qualifies as a mandatory abuse reporter shall have completed approved abuse education training as follows.

a. Mandatory reporter of child abuse. A pharmacist who qualifies as a mandatory reporter of child abuse shall have completed two hours of training in child abuse identification and reporting within the previous five years.

b. Mandatory reporter of dependent adult abuse. A pharmacist who qualifies as a mandatory reporter of dependent adult abuse shall have completed two hours of training in dependent adult abuse identification and reporting within the previous five years.

c. Mandatory reporter of child abuse and dependent adult abuse. A pharmacist who qualifies as a mandatory reporter of child abuse and dependent adult abuse may complete separate courses pursuant to paragraphs “a” and “b” or may complete, within the previous five years, one combined two-hour course that includes curricula for identifying and reporting child abuse and dependent adult abuse.

2.16(2) Persons exempt from training requirements. The requirements of this rule shall not apply to a pharmacist during periods that the pharmacist serves honorably on active duty in the military or during periods that the pharmacist resides outside Iowa and does not practice pharmacy in Iowa.

2.16(3) Mandatory training records. A pharmacist subject to the requirements of this rule shall maintain documentation of completion of the mandatory training for identifying and reporting abuse, including dates, subjects, duration of programs, and proof of participation, for five years following the date of the training. The board may audit this information at any time within the five-year period.

2.16(4) Approved programs. “Approved abuse education training” means a training program using a curriculum approved by the abuse education review panel of the Iowa department of public health.

657—2.17(272C) Continuing professional development portfolio. A pharmacist may complete and submit with the pharmacist’s license renewal a CPD portfolio to fulfill the CPE requirements in rule 657—2.12(272C).

2.17(1) Prerequisite. A pharmacist, prior to submitting the pharmacist’s initial CPD portfolio, shall complete an ACPE-accredited provider activity regarding the objectives and processes relating to CPD. Record of the pharmacist’s participation in this prerequisite activity shall be included in the pharmacist’s initial CPD portfolio.
2.17(2) CPD portfolio requirements. A pharmacist shall combine traditional CPE activities with professional development activities. The pharmacist shall incorporate the record of completion and evaluation of any traditional CPE activities into the CPD portfolio.

a. The pharmacist is responsible for ensuring that the activity content identified in the CPD portfolio directly relates to the pharmacist’s professional practice and career goals.

b. The pharmacist is responsible for ensuring that the activities identified in the CPD portfolio comply with the CPE topic requirements identified in subrules 2.12(4) and 2.17(3).

2.17(3) CPD portfolio content. In addition to the record of completion of the one-time prerequisite activity identified in subrule 2.17(1), a completed CPD portfolio shall include or identify the following:

a. A minimum of 30 documented learning outcomes in the form of completed learning statements on forms provided by the board.

b. Documented learning outcomes shall include a minimum of two outcomes relating to patient or medication safety, two outcomes relating to pharmacy law, 15 outcomes relating to drug therapy, and if the pharmacist is engaged in the administration of immunizations or vaccines, one outcome relating to vaccine administration.

c. Documented learning outcomes shall include any number of CPE activities that carry the seal of an ACPE-accredited provider. Successful completion and record of these CPE activities in CPE Monitor as provided in subrule 2.12(3), in addition to the documented CPD learning outcomes, is required for the pharmacist to receive credit for these activities.

d. Documented learning outcomes shall include any CPE activities provided by non-ACPE, accredited, health-professional continuing education providers pursuant to paragraph 2.12(2) “b. ”

2.17(4) CPD portfolio review. The board shall review or may contract for peer review of CPD portfolios submitted for pharmacist license renewal. The board shall respond to a submitting pharmacist with comments, suggestions, and recommendations regarding the pharmacist’s CPD portfolio and processes.

[ARC 0595C, IAB 2/6/13, effective 3/13/13; ARC 4579C, IAB 7/31/19, effective 9/4/19]

These rules are intended to implement Iowa Code sections 147.10, 147.36, 147.94, 147.96, 155A.8, 155A.9, 155A.11, 155A.39, and 272C.2.

[Filed 4/11/68; amended 11/14/73]
[Filed 11/24/76, Notice 10/20/76—published 12/15/76, effective 1/19/77]
[Filed 1/30/80, Notice 12/26/79—published 2/20/80, effective 6/1/80]
[Filed 9/24/80, Notice 6/25/80—published 10/15/80, effective 11/19/80]
[Filed 12/1/80, Notice 9/3/80—published 12/24/80, effective 1/28/81]
[Filed 6/16/83, Notice 5/11/83—published 7/6/83, effective 8/10/83]
[Filed 11/14/85, Notice 8/28/85—published 12/4/85, effective 1/8/86]
[Filed 5/14/86, Notice 4/9/86—published 6/4/86, effective 7/9/86]
[Filed 1/28/87, Notice 11/19/86—published 2/25/87, effective 4/1/87]
[Filed 8/5/87, Notice 6/3/87—published 8/26/87, effective 9/30/87]
[Filed emergency 1/21/88—published 2/10/88, effective 1/22/88]
[Filed 11/17/88, Notice 8/24/88—published 12/14/88, effective 1/18/89]
[Filed emergency 5/16/89—published 6/14/89, effective 5/17/89]
[Filed 1/29/91, Notice 9/19/90—published 2/20/91, effective 3/27/91]
[Filed emergency 5/10/91—published 5/29/91, effective 5/10/91]
[Filed 2/27/97, Notices 8/28/96, 1/1/97—published 3/26/97, effective 4/30/97]
[Filed 6/23/97, Notice 4/9/97—published 7/16/97, effective 8/20/97]
[Filed 11/19/97, Notice 10/8/97—published 12/17/97, effective 1/21/98]
[Filed 7/31/98, Notice 5/20/98—published 8/26/98, effective 10/15/98]
[Filed 8/14/02, Notice 6/12/02—published 9/4/02, effective 10/9/02]
[Filed 7/15/03, Notice 4/16/03—published 8/6/03, effective 9/10/03]
[Filed emergency 7/16/04 after Notice 6/9/04—published 8/4/04, effective 7/16/04]
[Filed emergency 6/30/05 after Notice 5/11/05—published 7/20/05, effective 7/1/05]
[Filed 3/22/06, Notice 1/18/06—published 4/12/06, effective 5/17/06]
[Filed 5/17/06, Notice 4/12/06—published 6/7/06, effective 7/12/06]
[Filed 2/7/07, Notice 10/25/06—published 2/28/07, effective 4/4/07]
[Filed emergency 11/13/07 after Notice 8/29/07—published 12/5/07, effective 11/13/07]
[Filed 11/24/08, Notice 10/8/08—published 12/17/08, effective 1/21/09]
[Filed ARC 8672B (Notice ARC 8412B, IAB 12/30/09), IAB 4/7/10, effective 5/12/10]
[Filed ARC 9406B (Notice ARC 9192B, IAB 11/3/10), IAB 3/9/11, effective 4/13/11]
[Filed ARC 9782B (Notice ARC 9554B, IAB 6/15/11), IAB 10/5/11, effective 11/9/11]
[Filed ARC 0504C (Notice ARC 0351C, IAB 10/3/12), IAB 12/12/12, effective 1/16/13]
[Filed ARC 0595C (Notice ARC 0511C, IAB 12/12/12), IAB 2/6/13, effective 3/13/13]
[Filed ARC 1031C (Notice ARC 0884C, IAB 7/24/13), IAB 9/18/13, effective 10/23/13]
[Filed ARC 3099C (Notice ARC 2859C, IAB 12/7/16), IAB 6/7/17, effective 7/12/17]
[Filed ARC 3636C (Notice ARC 3369C, IAB 10/11/17), IAB 2/14/18, effective 3/21/18]
[Filed ARC 4579C (Notice ARC 4391C, IAB 4/10/19), IAB 7/31/19, effective 9/4/19]
CHAPTER 4
PHARMACIST-INTERNS
[Prior to 2/10/88, see Pharmacy Examiners[620] Ch 3]

657—4.1(155A) Definitions.

“Board” means the Iowa board of pharmacy.

“Pharmacist-intern” or “intern” means a person enrolled in a college of pharmacy or actively pursuing a pharmacy degree, or as otherwise provided by the board, who is registered with the board for the purpose of obtaining instruction in the practice of pharmacy from a preceptor pursuant to Iowa Code section 155A.6. “Pharmacist-intern” includes a graduate of an approved college of pharmacy, or a foreign graduate who has established educational equivalency pursuant to the requirements of rule 657—4.7(155A), who is registered with the board for the purpose of obtaining practical experience as a requirement for licensure as a pharmacist in Iowa. “Pharmacist-intern” may include an individual participating in a residency or fellowship program in Iowa, whether or not the individual is licensed as a pharmacist in another state.

“Pharmacist preceptor” or “preceptor” means a pharmacist licensed to practice pharmacy whose license is current and in good standing. Preceptors shall meet the conditions and requirements of rule 657—4.9(155A). No pharmacist shall serve as a preceptor while the pharmacist’s license to practice pharmacy is the subject of disciplinary sanction by a pharmacist licensing authority.

[ARC 9784B, IAB 10/5/11, effective 11/9/11; ARC 1406C, IAB 4/2/14, effective 5/7/14]

657—4.2(155A) Goal and objectives of internship.

4.2(1) Goal. The goal of internship is for the pharmacist-intern, over a period of time, to attain and build upon the knowledge, skills, responsibilities, and ability to safely, efficiently, and effectively practice pharmacy under the laws and rules of the state of Iowa.

4.2(2) Objectives. The objectives of internship are as follows:

a. Managing drug therapy to optimize patient outcomes. The pharmacist-intern shall evaluate the patient and patient information to determine the presence of a disease or medical condition, to determine the need for treatment or referral, and to identify patient-specific factors that affect health, pharmacotherapy, or disease management; ensure the appropriateness of the patient’s specific pharmacotherapeutic agents, dosing regimens, dosage forms, routes of administration, and delivery systems; and monitor the patient and patient information and manage the drug regimen to promote health and ensure safe and effective pharmacotherapy.

b. Ensuring the safe and accurate preparation and dispensing of medications. The pharmacist-intern shall perform calculations required to compound, dispense, and administer medication; select and dispense medications; and prepare and compound extemporaneous preparations and sterile products.

c. Providing drug information and promoting public health. The pharmacist-intern shall access, evaluate, and apply information to promote optimal health care; educate patients and health care professionals regarding prescription medications, nonprescription medications, and medical devices; and educate patients and the public regarding wellness, disease states, and medical conditions.

d. Adhering to professional and ethical standards. The pharmacist-intern shall comply with professional, legal, moral, and ethical standards relating to the practice of pharmacy and the operation of the pharmacy.

e. Understanding the management of pharmacy operations. The pharmacist-intern shall develop a general understanding of the business procedures of a pharmacy and develop knowledge concerning the employment and supervision of pharmacy employees.

657—4.3(155A) 1500-hour requirements. Internship credit may be obtained only after internship registration with the board and commencement of the first professional year in a college of pharmacy. Internship shall consist of a minimum of 1500 hours, all of which may be a college-based clinical program approved or accepted by the board. Programs shall be structured to provide experience in community, institutional, and clinical pharmacy practices. A pharmacist-intern may acquire additional
hours under the supervision of one or more preceptors in a traditional licensed general or hospital pharmacy, at a rate of no more than 48 hours per week, where the goal and objectives of internship in rule 657—4.2(155A) apply. Credit toward any additional hours will be allowed, at a rate not to exceed 10 hours per week, for an internship served concurrent with academic training and outside a college-based clinical program. “Concurrent time” means internship experience acquired while the person is a full-time student carrying, in a given school term, at least 75 percent of the average number of credit hours per term needed to graduate and receive an entry-level degree in pharmacy. Recognized academic holiday periods, such as spring break and winter break, shall not be considered “concurrent time.” The competencies in subrule 4.2(2) and the concurrent time limitations of this rule shall not apply to college-based clinical programs.

[ARC 1406C; IA ß 4/2/14, effective 5/7/14]

657—4.4(155A) Iowa colleges of pharmacy clinical internship programs. The board shall periodically review the clinical component of internship programs of the colleges of pharmacy located in Iowa. The board reserves the right to set conditions relating to the approval of such programs.

657—4.5(155A) Out-of-state internship programs. Candidates enrolled in out-of-state colleges of pharmacy who complete the internship requirements of that state shall be deemed to have satisfied Iowa’s internship requirements. Candidates shall submit documentation from the out-of-state internship program certifying completion of that state’s requirements. Candidates enrolled in colleges of pharmacy located in states with no formal internship training program shall submit documentation from that state’s board of pharmacy or college of pharmacy certifying that the candidate has completed all prelicensure training requirements.

657—4.6(155A) Registration, reporting, and authorized functions. Every person shall register with the board before beginning the person’s internship experience, whether or not for the purpose of fulfilling the requirements of rule 657—4.3(155A). Registration is required of all students enrolled in Iowa colleges of pharmacy upon commencement of the first professional year in the college of pharmacy. Colleges of pharmacy located in Iowa shall annually certify to the board the names of students who are enrolled in the first professional year in the college of pharmacy. Colleges of pharmacy located in Iowa shall, within two weeks of any change, certify to the board the names of students who have withdrawn from the college of pharmacy.

4.6(1) Application for registration—required information. Application for registration as a pharmacist-intern shall be on forms provided by the board, and all requested information shall be provided on or with such application. The application shall require that the applicant provide, at a minimum, the following: name; address; telephone number; date of birth; social security number or individual tax identification number (ITIN); and name and location of college of pharmacy and anticipated month and year of graduation. The college of pharmacy shall certify the applicant’s eligibility to practice as a pharmacist-intern.

4.6(2) Supervision and authorized functions. A licensed pharmacist shall be on duty in the pharmacy and shall be responsible for the actions of a pharmacist-intern during all periods of internship training. At the discretion of the supervising pharmacist, the following judgmental functions, usually restricted to a pharmacist, may be delegated to pharmacist-interns registered by the board:

a. Verification of the accuracy, validity, and appropriateness of the filled prescription or medication order;

b. Review and assessment of patient records for purposes identified in rule 657—8.21(155A);

c. Patient counseling;

d. Administration of vaccines pursuant to rule 657—39.10(155A).

4.6(3) Term of registration. Registration shall remain in effect as long as the board is satisfied that the intern is pursuing a degree in pharmacy in good faith and with reasonable diligence. A pharmacist-intern may request that the intern’s registration be extended beyond the automatic termination of the registration pursuant to the procedures and requirements of 657—Chapter 34. Except as provided by the definition
of pharmacist-intern in rule 657—4.1(155A), registration shall automatically terminate upon the earliest of any of the following:

a. Licensure to practice pharmacy in any state;
b. Lapse in the pursuit of a degree in pharmacy; or
c. One year following graduation from the college of pharmacy.

4.6(4) Identification, reports, and notifications. Credit for internship time will not be granted unless registration and other required records or affidavits are completed.

a. The pharmacist-intern shall be so designated in all relationships with the public and health professionals. While on duty in the pharmacy, the intern shall wear visible to the public a name badge including the designation “pharmacist-intern” or “pharmacy student.”
b. Registered interns shall notify the board office within ten days of a change of name or address.
c. Notarized affidavits of experience in non-college-sponsored programs shall be submitted to the board no later than six months following graduation from a school or college of pharmacy. These affidavits shall certify only the number of hours and dates of training obtained outside a college-based clinical program as provided in rule 657—4.3(155A). An individual registered as a pharmacist-intern while participating in an Iowa residency or fellowship program shall not be required to file affidavits of experience.

4.6(5) No credit prior to registration. Credit will not be given for internship experience obtained prior to the individual’s registration as a pharmacist-intern. Credit for Iowa college-based clinical programs will not be granted unless registration is issued before the student begins the program.

4.6(6) Nontraditional internship. Internship training at any site which is not licensed as a general or hospital pharmacy is considered nontraditional internship.

a. Application. Prior to beginning a period of nontraditional internship, the intern shall submit a written application, on forms provided by the board, for approval of the objectives of the nontraditional internship. The application shall identify objectives consistent with unique learning experiences of the intern and consistent with the goal and objectives of internship in rule 657—4.2(155A).
b. Preceptor. A preceptor supervising a pharmacist-intern in a nontraditional internship shall be a currently licensed pharmacist in the state where the internship is served, and the requirements of rule 657—4.9(155A) shall apply to all preceptors.
c. Certification, not credit. Hours obtained in nontraditional internship shall not be credited toward the total 1500 hours required pursuant to rule 657—4.3(155A) prior to licensure to practice pharmacy in Iowa. The board may, however, certify hours obtained in one or more approved nontraditional internships in recognition of the pharmacist-intern’s training outside the scope of traditional pharmacy practice. Certification shall not be granted for experience obtained in a nontraditional internship unless the board, prior to the intern’s beginning the period of internship, approved the objectives of the internship.

[ARC 9784B, IAB 10/5/11, effective 11/9/11; ARC 1406C, IAB 4/2/14, effective 5/7/14; ARC 1786C, IAB 12/10/14, effective 1/14/15; ARC 2405C, IAB 2/17/16, effective 3/23/16; ARC 3858C, IAB 6/20/18, effective 7/25/18; ARC 4579C, IAB 7/31/19, effective 9/4/19]

657—4.7(155A) Foreign pharmacy graduates. Foreign pharmacy graduates who are candidates for licensure in Iowa will be required to obtain a minimum of 1500 hours of internship in a licensed pharmacy or other board-approved location.

4.7(1) Registration. Candidates shall register with the board as provided in rule 657—4.6(155A). Internship credit will not be granted until the candidate has been issued an intern registration. Applications for registration shall be accompanied by certification from the Foreign Pharmacy Graduate Examination Committee (FPGEC) as provided in 657—subrule 2.10(1).

4.7(2) Certification of hours. Following completion of any period of internship, internship hours shall be certified to the board by submission of notarized affidavits of experience as provided in paragraph 4.6(4) “c.”

[ARC 1406C, IAB 4/2/14, effective 5/7/14; ARC 4579C, IAB 7/31/19, effective 9/4/19]
657—4.8(155A) Fees. The fee for registration as a pharmacist-intern is $30, plus applicable surcharge pursuant to 657—30.8(155A), which shall be payable with the application.

657—4.9(155A) Preceptor requirements.

4.9(1) Licensed pharmacist. A preceptor shall be a licensed pharmacist in good standing in the state where the internship is to be served pursuant to the definition of pharmacist preceptor in rule 657—4.1(155A).

4.9(2) Affidavits. A preceptor shall be responsible for completing the affidavit certifying the number of hours and the dates of each internship training period under the supervision of the preceptor for any period of internship completed outside a college-based clinical program.

4.9(3) Number of interns. For the purpose of internship, a preceptor may supervise no more than two pharmacist-interns concurrently.

4.9(4) Responsibility. A preceptor shall be responsible for all functions performed by a pharmacist-intern.

[ARC 1406C, IAB 4/2/14, effective 5/7/14; ARC 4266C, IAB 1/30/19, effective 3/6/19]

657—4.10(155A) Denial of pharmacist-intern registration. The board may deny an application for registration as a pharmacist-intern for any violation of the laws of this state, another state, or the United States relating to prescription drugs, controlled substances, or nonprescription drugs, or for any violation of Iowa Code chapter 124, 124B, 126, 147, 155A or 205, or any rule of the board.

[ARC 3857C, IAB 6/20/18, effective 7/25/18]

657—4.11(155A) Discipline of pharmacist-interns.

4.11(1) Grounds for discipline. The board may impose discipline for any violation of the laws of this state, another state, or the United States relating to prescription drugs, controlled substances, or nonprescription drugs or for any violation of Iowa Code chapter 124, 124B, 126, 147, 155A, or 205, or any rule of the board.

4.11(2) Sanctions. The board may impose the following disciplinary sanctions:

a. Revocation of a pharmacist-intern registration.

b. Suspension of a pharmacist-intern registration until further order of the board or for a specified period.

c. Prohibit permanently, until further order of the board, or for a specified period, the engaging in specified procedures, methods, or acts.

d. Such other sanctions allowed by law as may be appropriate.

[ARC 3857C, IAB 6/20/18, effective 7/25/18]

These rules are intended to implement Iowa Code section 155A.6.

[Filed 7/19/67; amended 2/13/73]

[Filed 11/24/76, Notice 10/20/76—published 12/15/76, effective 1/19/77]
[Filed 11/9/77, Notice 10/5/77—published 11/30/77, effective 1/4/78]
[Filed 10/20/78, Notice 8/9/78—published 11/15/78, effective 1/9/79]
[Filed 9/10/82, Notice 6/9/82—published 9/29/82, effective 11/8/82]
[Filed emergency 1/21/88—published 2/10/88, effective 1/22/88]
[Filed 11/17/88, Notice 8/24/88—published 12/14/88, effective 1/18/89]
[Filed emergency 5/16/89—published 6/14/89, effective 5/17/89]
[Filed 8/31/90, Notice 6/13/90—published 9/19/90, effective 10/24/90]
[Filed 4/26/91, Notice 2/20/91—published 5/15/91, effective 6/19/91]
[Filed 12/10/96, Notice 8/28/96—published 1/1/97, effective 2/5/97]
[Filed 2/27/97, Notice 1/1/97—published 3/26/97, effective 4/30/97]
[Filed 2/18/00, Notice 12/15/99—published 3/22/00, effective 4/26/00]
[Filed 2/7/01, Notice 10/18/00—published 3/7/01, effective 4/11/01]
[Filed 8/14/02, Notice 6/12/02—published 9/4/02, effective 10/9/02]
[Filed 12/22/04, Notice 11/10/04—published 1/19/05, effective 2/23/05]
[Filed 3/22/06, Notice 1/18/06—published 4/12/06, effective 5/17/06]
[Filed ARC 9784B (Notice ARC 9555B, IAB 6/15/11), IAB 10/5/11, effective 11/9/11]
[Filed ARC 1406C (Notice ARC 1237C, IAB 12/11/13), IAB 4/2/14, effective 5/7/14]
[Filed ARC 1786C (Notice ARC 1652C, IAB 10/1/14), IAB 12/10/14, effective 1/14/15]
[Filed ARC 2405C (Notice ARC 2301C, IAB 12/9/15), IAB 2/17/16, effective 3/23/16]
[Filed ARC 3857C (Notice ARC 3506C, IAB 12/20/17), IAB 6/20/18, effective 7/25/18]
[Filed ARC 3858C (Notice ARC 3509C, IAB 12/20/17), IAB 6/20/18, effective 7/25/18]
[Filed ARC 4266C (Notice ARC 4091C, IAB 10/24/18), IAB 1/30/19, effective 3/6/19]
[Filed ARC 4579C (Notice ARC 4391C, IAB 4/10/19), IAB 7/31/19, effective 9/4/19]
CHAPTER 8
UNIVERSAL PRACTICE STANDARDS
[Prior to 2/10/88, see Pharmacy Examiners[620] Ch 6]

657—8.1(155A) Purpose and scope. The purpose of this chapter is to establish the minimum standards of pharmacy practice for the activities identified in this chapter. The requirements of these rules shall apply to all Iowa-licensed pharmacists, other registered pharmacy personnel, and all pharmacies, including owners, providing the services addressed in this chapter to patients in Iowa. These rules are in addition to rules of the board relating to specific types of pharmacy licenses issued by the board unless otherwise indicated by rule.
[ARC 3858C; IAB 6/20/18, effective 7/25/18]

657—8.2(155A) Definitions. For the purpose of this chapter, the following definitions shall apply:

“Board” means the Iowa board of pharmacy.

“Confidential information” means information accessed or maintained by the pharmacy in the patient’s or the pharmacy’s records which contains personally identifiable information that could be used to identify the patient. “Confidential information” includes but is not limited to patient name, address, telephone number, and social security number; prescriber name and address; and prescription and drug or device information such as therapeutic effect, diagnosis, allergies, disease state, pharmaceutical services rendered, medical information, and drug interactions.

“DEA” means the United States Department of Justice, Drug Enforcement Administration.

“Pharmacy support person” or “PSP” means a person, other than a member of the professional pharmacy staff, registered with the board who may perform nontechnical duties assigned by a supervising pharmacist under the pharmacist’s responsibility and supervision.

“Professional pharmacy staff” shall mean the professional employees of the pharmacy, including pharmacists, pharmacy technicians, and pharmacist-interns.

This rule is intended to implement Iowa Code chapter 155A.
[ARC 3858C; IAB 6/20/18, effective 7/25/18]

657—8.3(155A) Responsible parties.

8.3(1) Pharmacist in charge. One professionally competent, legally qualified pharmacist in charge in each pharmacy shall work cooperatively with the pharmacy, by and through its owner or license holder, and with all staff pharmacists to ensure the legal operation of the pharmacy, including meeting all inspection and other requirements of state and federal laws, rules, and regulations governing the practice of pharmacy. A part-time pharmacist in charge has the same obligations and responsibilities as a full-time pharmacist in charge.

8.3(2) Pharmacy. Each pharmacy, by and through its owner or license holder, shall work cooperatively with the pharmacist in charge and with all staff pharmacists to ensure the legal operation of the pharmacy, including meeting all inspection and other requirements of state and federal laws, rules, and regulations governing the practice of pharmacy. The pharmacy, by and through its owner or license holder, shall be responsible for employing a professionally competent, legally qualified pharmacist in charge. The pharmacy, by and through its owner or license holder, may be held responsible for unethical conduct or practices of any of the pharmacy staff.

8.3(3) Pharmacy and pharmacist in charge. The pharmacist in charge and the pharmacy, by and through its owner or license holder, shall share responsibility for, at a minimum, the following:

a. Ensuring that the pharmacy employs an adequate number of qualified personnel commensurate with the size and scope of services provided by the pharmacy.

b. Ensuring the availability of any equipment and references necessary for the particular practice of pharmacy.

c. Ensuring that there is adequate space within the prescription department or a locked room not accessible to the public for the storage of prescription drugs, including controlled substances, devices, and pharmacy records, and to support the operations of the pharmacy.
d. Ensuring that the license, registration, or certification of each professional pharmacy staff member and the registration of each pharmacy support person are maintained in current and active status.

8.3(4) **Pharmacist in charge and staff pharmacists.** The pharmacist in charge and staff pharmacists shall share responsibility for, at a minimum, the following:

a. Ensuring that a pharmacist performs prospective drug use review as specified in rule 657—8.21(155A).

b. Ensuring that a pharmacist or pharmacist-intern provides patient counseling as specified in rule 657—6.14(155A).

c. Dispensing drugs to patients, including the packaging, preparation, compounding, and labeling functions performed by pharmacy personnel.

d. Delivering drugs to the patient or the patient’s agent.

e. Ensuring that patient medication records are maintained as specified in rule 657—6.13(155A).

f. Training and supervising pharmacist-interns, pharmacy technicians, pharmacy support persons, and other pharmacy employees.

g. Procuring and storing prescription drugs and devices and other products dispensed from the pharmacy.

h. Distributing and disposing of drugs from the pharmacy.

i. Maintaining records of all transactions of the pharmacy necessary to maintain accurate control over and accountability for all drugs as required by applicable state and federal laws, rules, and regulations.

j. Ensuring the legal operation of the pharmacy, including meeting all inspection and other requirements of state and federal laws, rules, and regulations governing the practice of pharmacy.

8.3(5) **Pharmacy, pharmacist in charge, and staff pharmacists.** The pharmacy, by and through its owner or license holder, the pharmacist in charge, and all staff pharmacists shall share responsibility for, at a minimum, the following:

a. Establishing and periodically reviewing (by the pharmacy and the pharmacist in charge), implementing (by the pharmacist in charge), and complying (by the pharmacist in charge and staff pharmacists) with policies and procedures for all operations of the pharmacy. The policies and procedures shall identify the frequency of review.

b. Establishing and maintaining effective controls against the theft or diversion of prescription drugs, including controlled substances, and records for such drugs.

c. Establishing (by the pharmacy and the pharmacist in charge), implementing (by the pharmacist in charge), and utilizing (by the pharmacist in charge and staff pharmacists) an ongoing, systematic program of continuous quality improvement for achieving performance enhancement and ensuring the quality of pharmaceutical services.

8.3(6) **Practice functions.** The pharmacist is responsible for all functions performed in the practice of pharmacy. The pharmacist maintains responsibility for any and all delegated functions including functions delegated to pharmacist-interns, pharmacy technicians, and pharmacy support persons.

[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 1576C, IAB 8/20/14, effective 9/24/14; ARC 1961C, IAB 4/15/15, effective 5/20/15; ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—8.4(155A) **Pharmacist identification and staff logs.**

8.4(1) **Display of pharmacist license.** During any period a pharmacist is working in a pharmacy, each pharmacist shall display, in a position visible to the public, an original license to practice pharmacy in Iowa. A current license renewal certificate, which may be a photocopy of an original renewal certificate, shall be displayed with the original license.

8.4(2) **Registration maintained of pharmacy personnel.** Each pharmacist-intern, pharmacy technician, and pharmacy support person shall maintain current registration with the board. The registration certificate or a copy of the registration certificate shall be readily retrievable upon request of the board or its authorized agent.
8.4(3) Identification codes. A permanent log of the initials or identification code identifying by name each pharmacist, pharmacist-intern, pharmacy technician, and pharmacy support person shall be maintained for a minimum of two years and shall be available for inspection and copying by the board or its representative. The initials or identification code shall be unique to the individual to ensure that each pharmacist, pharmacist-intern, pharmacy technician, and pharmacy support person can be identified.

8.4(4) Temporary or intermittent pharmacy staff. The pharmacy shall maintain a log of all pharmacists, pharmacist-interns, pharmacy technicians, and pharmacy support persons who have worked at that pharmacy and who are not regularly staffed at that pharmacy. Such log shall include the dates and shifts worked by each pharmacist, pharmacist-intern, pharmacy technician, and pharmacy support person and shall be available for inspection and copying by the board or its representative for a minimum of two years following the date of the entry.

8.4(5) Identification. While on duty, pharmacy personnel shall wear visible identification that clearly identifies the person by licensed or registered title and includes at least the person’s first name.

[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 9409B, IAB 3/9/11, effective 4/13/11; ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—8.5(155A) Environment and equipment requirements. There shall be adequate space, equipment, and supplies for the professional and administrative functions of the pharmacy pursuant to rule 657—8.3(155A). Space and equipment shall be available in an amount and type to provide secure, environmentally controlled storage of drugs.

8.5(1) Refrigeration. The pharmacy shall maintain one or more refrigeration units, unless the pharmacy does not stock refrigerated items. The pharmacy shall document verification that the temperature of the refrigerator is maintained within a range compatible with the proper storage of drugs requiring refrigeration. If the temperature is manually or visually verified, a record of minimum daily verification shall be maintained.

8.5(2) Sink. The pharmacy shall have a sink with hot and cold running water located within the pharmacy department and available to all pharmacy personnel; the sink shall be maintained in a sanitary condition.

8.5(3) Secure barrier. A pharmacy department shall be closed and secured in the absence of the pharmacist except as provided in rule 657—6.7(124,155A) or 657—7.5(124,155A). To ensure that secure closure, the pharmacy department shall be surrounded by a physical barrier capable of being securely locked to prevent entry when the department is closed. A secure barrier may be constructed of other than a solid material with a continuous surface if the openings in the material are not large enough to permit removal of items from the pharmacy department by any means. Any material used in the construction of the barrier shall be of sufficient strength and thickness that it cannot be readily or easily removed, penetrated, or bent.

8.5(4) Remodel or relocation—inspection. A pharmacy planning to remodel or relocate a licensed pharmacy department on or within the premises currently occupied by the pharmacy department, or a pharmacy intending to remodel or install a sterile compounding facility or equipment, shall provide written notification to the board at least 30 days prior to commencement of the remodel, pharmacy relocation, or sterile compounding installation. The board may require on-site inspection of the facility, equipment, or pharmacy department prior to or during the pharmacy’s remodel, relocation, or opening. The board may also require on-site inspection of a temporary pharmacy location intended to be utilized during the remodel, construction, or relocation of the pharmacy department.

8.5(5) Orderly and clean. The pharmacy shall be arranged in an orderly fashion and kept clean. All required equipment shall be in good operating condition and maintained in a sanitary manner. Animals shall not be allowed within a licensed pharmacy unless that pharmacy is exclusively providing services for the treatment of animals or unless the animal is a service dog or assistive animal as defined in Iowa Code subsection 216C.11(1).

8.5(6) Light, ventilation, temperature, and humidity. The pharmacy shall be properly lighted and ventilated. The temperature and humidity of the pharmacy shall be maintained within a range compatible with the proper storage of drugs.
8.5(7) **Other equipment.** The pharmacist in charge and the pharmacy, by and through its owner or license holder, shall share the responsibility for ensuring the availability of any other equipment necessary for the particular practice of pharmacy and to meet the needs of the patients served by the pharmacy.

8.5(8) **Bulk counting machines.** Unless bar-code scanning is required and utilized to verify the identity of each stock container of drugs utilized to restock a counting machine cell or bin, a pharmacist shall verify the accuracy of the drugs to be restocked prior to filling the counting machine cell or bin. A record identifying the individual who verified the drugs to be restocked, the individual who restocked the counting machine cell or bin, and the date shall be maintained. Established policies and procedures shall include a method to calibrate and verify the accuracy of the counting device. The pharmacy shall, at least quarterly, verify the accuracy of the device and maintain a dated record identifying the individual who performed the quarterly verification.

8.5(9) **Authorized collection program.** A pharmacy that is registered with the DEA to administer an authorized collection program shall provide adequate space, equipment, and supplies for such collection program pursuant to 657—Chapter 10 and federal regulations for authorized collection programs, which can be found at www.deadversion.usdoj.gov/drug_disposal/.

8.5(10) **Health of personnel.** The pharmacist in charge or supervising pharmacist shall ensure that pharmacy personnel experiencing any health condition that may have an adverse effect on drug products or may pose a health or safety risk to others be prohibited from working in the pharmacy until such health condition is sufficiently resolved. All personnel who normally assist the pharmacist shall report to the pharmacist any health conditions that may have an adverse effect on drug products or may pose a health or safety risk to others.

8.5(11) **Hazardous drugs.** The pharmacy shall ensure pharmacy personnel and patients are adequately protected from unnecessary exposure to hazardous drugs. As of December 1, 2019, the pharmacy shall be in compliance with United States Pharmacopeia (USP) General Chapter 800 for handling hazardous drugs. A pharmacy engaged in compounding of hazardous drugs may request delayed compliance for specific requirements in USP General Chapter 800 pertaining to compounding, in accordance with rule 657—20.5(126,155A).

[ARC 8671B, IAB 4/7/10, effective 5/12/10; ARC 8503C, IAB 12/12/12, effective 1/16/13; ARC 1961C, IAB 4/15/15, effective 5/20/15; ARC 2408C, IAB 2/17/16, effective 3/23/16; ARC 3858C, IAB 6/20/18, effective 7/25/18; ARC 4267C, IAB 1/30/19, effective 3/6/19; ARC 4454C, IAB 5/22/19, effective 6/26/19]

657—8.6(155A) **Health of personnel.** Rescinded ARC 3858C, IAB 6/20/18, effective 7/25/18.

657—8.7(155A) **Procurement, storage, and recall of drugs and devices.**

8.7(1) **Source.** Procurement of prescription drugs and devices shall be from an Iowa-licensed distributor or, on a limited basis, from another licensed pharmacy or licensed practitioner located in the United States.

8.7(2) **Manner of storage.** Drugs and devices shall be stored in a manner to protect their identity and integrity.

8.7(3) **Storage temperatures.** All drugs and devices shall be stored at the proper temperature as provided in manufacturer labeling. In the absence of a specific temperature range, the pharmacy shall defer to storage conditions identified in United States Pharmacopeia chapter 659.

8.7(4) **Product recall.** There shall be a system for removing from use, including unit dose, any drugs and devices subjected to a product recall.

8.7(5) **Outdated drugs or devices.** Any drug or device bearing an expiration date shall not be dispensed for use beyond the expiration date of the drug or device. Outdated drugs or devices shall be removed from dispensing stock and shall be quarantined until such drugs or devices are properly disposed of.

8.7(6) **Records.** All pharmacies shall maintain supplier invoices of prescription drugs and controlled substances upon which the actual date of receipt of the drugs by the pharmacist or other responsible individual is clearly recorded. All pharmacies shall maintain supplier credit memos. Pharmacy records
of invoices and credit memos shall be maintained for at least two years from the date of the record. If the original supplier invoice or credit memo is received electronically, hard-copy record is not required. [ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—8.8(124,155A) Out-of-date drugs or devices. Rescinded ARC 3858C, IAB 6/20/18, effective 7/25/18.

657—8.9(124,155A) Records storage. Every record required to be maintained by a pharmacy pursuant to board rules or Iowa Code chapters 124 and 155A shall be maintained and be available for inspection and copying by the board or its representative for at least two years from the date of such record or the date of last activity on the record unless a longer retention period is specified for the particular record.

8.9(1) Records less than 12 months old. Records shall be maintained within the licensed pharmacy department for a minimum of 12 months, except as provided herein. Pharmacy records less than 12 months old may be stored in a secure storage area outside the licensed pharmacy department, including at a remote location, if the pharmacy has retained electronic copies of the records in the pharmacy that are immediately available and if the original records are available within 48 hours of a request by the board or its authorized agent, unless such remote storage is prohibited under federal law.

8.9(2) Records more than 12 months old. Records more than 12 months old may be maintained in a secure storage area outside the licensed pharmacy department, including at a remote location, if the records are retrievable within 48 hours of a request by the board or its authorized agent, unless such remote storage is prohibited under federal law. [ARC 8539B, IAB 2/24/10, effective 4/1/10; ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—8.10 Reserved.

657—8.11(147,155A) Unethical conduct or practice. The provisions of this rule apply to licensed pharmacies, licensed pharmacists, registered pharmacy technicians, registered pharmacy support persons, and registered pharmacist-interns.

8.11(1) Misrepresentative deeds. A pharmacy, pharmacist, technician, support person, or pharmacist-intern shall not make any statement intended to deceive, misrepresent or mislead anyone, or be a party to or an accessory to any fraudulent or deceitful practice or transaction in pharmacy or in the operation or conduct of a pharmacy.

8.11(2) Unethical conduct.

a. A pharmacy, pharmacist, pharmacist-intern, technician, or support person shall not participate in any of the following types of unethical conduct:

1. Any activity that negates a patient’s freedom of choice of pharmacy services.
2. Providing prescription blanks or forms bearing the pharmacy’s name or other means of identification to any person authorized to prescribe, except that a hospital may make prescription blanks or forms bearing the hospital pharmacy’s name or other means of identification available to hospital staff prescribers, emergency department prescribers, and prescribers granted hospital privileges for the prescribers’ use during practice at or in the hospital.
3. Any financial arrangement or transaction that would violate federal healthcare fraud, waste, and abuse laws, including but not limited to the Stark Law, the False Claims Act, and the Anti-Kickback Statute.

b. A purchasing pharmacist or pharmacy shall not engage in any activity or include in any agreement with a selling pharmacist or pharmacy any provision that would prevent or prohibit the prior notifications required in subrule 8.35(7).

8.11(3) Discrimination. A pharmacy, pharmacist, pharmacist-intern, technician, or pharmacy support person shall not discriminate between patients or groups of patients for reasons of religion, race, creed, color, gender, gender identity, sexual orientation, marital status, age, national origin, physical or mental disability, or disease state when providing pharmaceutical services.

8.11(4) Unprofessional conduct or behavior. A pharmacy, pharmacist, pharmacist-intern, technician, or pharmacy support person shall not engage in unprofessional behavior in connection
with the practice of pharmacy. Unprofessional behavior shall include, but not be limited to, the following acts: verbal abuse, coercion, intimidation, harassment, sexual advances, threats, degradation of character, indecent or obscene conduct, theft, and the refusal to provide reasonable information or answer reasonable questions for the benefit of the patient.

[ARC 9526B, IAB 6/1/11, effective 7/6/11; ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—8.12(126,147) Advertising. Prescription drug information, including price, may be provided to the public by a pharmacy so long as the information is not false or misleading and is not in violation of any federal or state laws applicable to the advertisement of such articles generally and if all of the following conditions are met:

1. All charges for services to the consumer shall be stated.
2. The effective dates for the prices listed shall be stated.
3. No reference shall be made to controlled substances listed in Schedules II through V of the latest revision of the Iowa uniform controlled substances Act and the rules of the board.

[ARC 3858C; IAB 6/20/18, effective 7/25/18]

657—8.13(135C,155A) Personnel histories. Pursuant to the requirements of Iowa Code section 135C.33, the provisions of this rule shall apply to any pharmacy employing any person to provide patient care services in a patient’s home. For the purposes of this rule, “employed by the pharmacy” shall include any individual who is paid to provide treatment or services to any patient in the patient’s home, whether the individual is paid by the pharmacy or by any other entity such as a corporation, a temporary staffing agency, or an independent contractor. Specifically excluded from the requirements of this rule are individuals such as delivery persons or couriers who do not enter the patient’s home for the purpose of instructing the patient or the patient’s caregiver in the use or maintenance of the equipment, device, or drug being delivered, or who do not enter the patient’s home for the purpose of setting up or servicing the equipment, device, or drug used to treat the patient in the patient’s home.

8.13(1) Applicant acknowledgment. The pharmacy shall ask the following question of each person seeking employment in a position that will provide in-home services: “Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime, in this state or any other state?” The applicant shall also be informed that a criminal history and child and dependent adult abuse record checks will be conducted. The applicant shall indicate, by signed acknowledgment, that the applicant has been informed that such record checks will be conducted.

8.13(2) Criminal history check. Prior to the employment of any person to provide in-home services as described by this rule, the pharmacy shall request that the department of public safety perform a criminal history check.

8.13(3) Abuse history checks. Prior to the employment of any person to provide in-home services as described by this rule, the pharmacy shall request that the department of human services perform a child and dependent adult abuse record check.

a. A person who has a criminal record, founded dependent adult abuse report, or founded child abuse report shall not be employed by a pharmacy to provide in-home services unless the department of human services has evaluated the crime or founded abuse report, has concluded that the crime or founded abuse does not merit prohibition from such employment, and has notified the pharmacy that the person may be employed to provide in-home services.

b. The pharmacy shall keep copies of all record checks and evaluations for a minimum of two years following receipt of the record or for a minimum of two years after the individual is no longer employed by the pharmacy, whichever is greater.

[ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—8.14(155A) Training and utilization of registered pharmacy staff. Pursuant to rule 657—8.3(155A), all Iowa-licensed pharmacies utilizing pharmacist-interns, pharmacy technicians, or pharmacy support persons shall have written policies and procedures for the training and utilization of pharmacist-interns, pharmacy technicians, and pharmacy support persons appropriate to the practice of pharmacy at that licensed location. Training shall be documented and maintained by the pharmacy for
at least two years from the last date of employment or internship and shall be available for inspection by the board or its authorized agent.  

[ARC 8673, IAB 4/7/10, effective 6/1/10; ARC 1961, IAB 4/15/15, effective 5/20/15; ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—8.15(155A) Delivery of prescription drugs and devices. Prescription drug orders, prescription devices, and completed prescription drug containers may be delivered, in compliance with all laws, rules, and regulations relating to the practice of pharmacy, to patients at any place of business licensed as a pharmacy.

8.15(1) Alternative methods. A licensed pharmacy may, by means of its employee or by use of a common carrier, pick up or deliver prescriptions to the patient or the patient’s caregiver as follows:

a. At the office or home of the prescriber.

b. At the residence of the patient or caregiver.

c. At the hospital or medical care facility in which a patient is confined.

d. At an outpatient medical care facility where the patient receives treatment only pursuant to the following requirements:

(1) The pharmacy shall obtain and maintain the written authorization of the patient or patient’s caregiver for receipt or delivery at the outpatient medical care facility;

(2) The prescription shall be delivered directly to or received directly from the patient, the caregiver, or an authorized agent identified in the written authorization;

(3) A prescription authorized by a prescriber not treating the patient at the outpatient medical care facility may be transmitted to the pharmacy by the authorized agent via facsimile provided that the means of transmission does not obscure or render the prescription information illegible due to security features of the paper utilized by the prescriber to prepare the prescription and provided that the original written prescription is delivered to the pharmacy prior to delivery of the filled prescription to the patient; and

(4) The outpatient medical care facility shall store the patient’s filled prescriptions in a secure area pending delivery to the patient.

e. At the patient’s or caregiver’s place of employment only pursuant to the following requirements:

(1) The pharmacy shall obtain and maintain the written authorization of the patient or patient’s caregiver for receipt or delivery at the place of employment;

(2) The prescription shall be delivered directly to or received directly from the patient, the caregiver, the prescriber, or an authorized agent identified in the written authorization; and

(3) The pharmacy shall ensure the security of confidential information.

8.15(2) Policies and procedures required. Pursuant to rule 657—8.3(155A), every pharmacy shipping or otherwise delivering prescription drugs or devices to Iowa patients shall have policies and procedures to ensure accountability, safe delivery, and compliance with temperature requirements as defined by subrule 8.7(3).

[ARC 7636, IAB 3/11/09, effective 4/15/09; ARC 1961, IAB 4/15/15, effective 5/20/15; ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—8.16(124,155A) Confidential information.

8.16(1) Release of confidential information. Confidential information may be released only as follows:

a. Pursuant to the express written authorization of the patient or the order or direction of a court.

b. To the patient or the patient’s authorized representative.

c. To the prescriber or other licensed practitioner then caring for the patient.

d. To another licensed pharmacist when the best interests of the patient require such release.

e. To the board or its representative or to such other persons or governmental agencies duly authorized by law to receive such information.

A pharmacist shall utilize the resources available to determine, in the professional judgment of the pharmacist, that any persons requesting confidential patient information pursuant to this rule are entitled to receive that information.

8.16(2) Exceptions. Nothing in this rule shall prohibit a pharmacist from releasing confidential patient information as follows:
a. Transferring a prescription to another pharmacy upon the request of the patient or the patient’s authorized representative or pursuant to subrule 8.35(7) when the pharmacy is discontinuing operations.

b. Providing the patient with a copy of a nonrefillable prescription that is clearly marked as a copy and not to be filled.

c. Providing drug therapy information to authorized practitioners for their patients.

d. Disclosing information necessary for the processing of third-party payer claims on behalf of the patient.

8.16(3) Record disposal. Disposal of any materials containing or including patient-specific or confidential information shall be conducted in a manner to preserve patient confidentiality.

[ARC 9526B, IAB 6/1/11, effective 7/6/11; ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—8.17 Reserved.

657—8.18(124,155A) Electronic prescription mandate. Beginning January 1, 2020, all prescriptions shall be transmitted electronically to a pharmacy pursuant to rule 657—21.6(124,155A), except as provided in rule 657—21.8(124,155A). A pharmacist who receives a written, oral, or facsimile prescription shall not be required to verify that the prescription is subject to an exception provided in rule 657—21.8(124,155A) and may dispense a prescription drug pursuant to an otherwise valid written, oral, or facsimile prescription pursuant to rule 657—8.19(124,126,155A).

[ARC 4580C, IAB 7/31/19, effective 9/4/19]

657—8.19(124,126,155A) Manner of issuance of a prescription drug or medication order. A prescription drug order or medication order that is issued prior to January 1, 2020, or that is exempt from the electronic prescription mandate pursuant to rule 657—21.8(124,155A) may be transmitted from a prescriber or a prescriber’s agent to a pharmacy in written form, orally including telephone voice communication, by facsimile transmission as provided in rule 657—21.7(124,155A), or by electronic transmission in accordance with applicable federal and state laws, rules, and regulations. Any prescription drug order or medication order provided to a patient in written or printed form shall include the original, handwritten signature of the prescriber except as provided in rule 657—21.6(124,155A).

8.19(1) Requirements for a prescription. A valid prescription drug order shall be based on a valid patient-prescriber relationship except as provided in subrule 8.19(7) for epinephrine auto-injectors and in subrule 8.19(8) for opioid antagonists.

a. Written, electronic, or facsimile prescription. In addition to the electronic prescription application and pharmacy prescription application requirements of this rule, a written, electronic, or facsimile prescription shall include:

1. The date issued.
2. The name and address of the patient except as provided in subrule 8.19(7) for epinephrine auto-injectors and in subrule 8.19(8) for opioid antagonists.
3. The name, strength, and quantity of the drug or device prescribed.
4. The name and address of the prescriber and, if the prescription is for a controlled substance, the prescriber’s DEA registration number.
5. The written or electronic signature of the prescriber.

b. Written prescription. In addition to the requirements of paragraph 8.19(1)“a,” a written prescription shall be manually signed, with ink or indelible pencil, by the prescriber. The requirement for manual signature shall not apply when an electronically prepared and signed prescription for a noncontrolled substance is printed on security paper as provided in 657—paragraph 21.6(2)“b.”

c. Facsimile prescription. In addition to the requirements of paragraph 8.19(1)“a,” a prescription transmitted via facsimile shall include:

1. The identification number of the facsimile machine used to transmit the prescription to the pharmacy.
2. The time and date of transmission of the prescription.
3. The name, address, telephone number, and facsimile number of the pharmacy to which the prescription is being transmitted.
(4) If the prescription is for a controlled substance and in compliance with DEA regulations, the manual signature of the prescriber.

d. **Electronic prescription.** In addition to the requirements of paragraph 8.19(1)“a,” an electronically prepared prescription for a controlled or noncontrolled prescription drug or device that is electronically transmitted to a pharmacy shall include the prescriber’s electronic signature, except as provided herein.

   (1) An electronically prepared prescription for a controlled substance that is printed out or faxed by the prescriber or the prescriber’s agent shall be manually signed by the prescriber.

   (2) The prescriber shall ensure that the electronic prescription application used to prepare and transmit the electronic prescription complies with applicable state and federal laws, rules, and regulations regarding electronic prescriptions.

   (3) The prescriber or the prescriber’s agent shall provide verbal verification of an electronic prescription upon the request of the pharmacy.

   (4) An electronic prescription for a noncontrolled prescription drug or device that is transmitted by an authorized agent shall not be required to contain the prescriber’s electronic signature.

**8.19(2) Verification.** The pharmacist shall exercise professional judgment regarding the accuracy, validity, and authenticity of any prescription drug order or medication order consistent with federal and state laws, rules, and regulations. In exercising professional judgment, the prescriber and the pharmacist shall take adequate measures to guard against the diversion of prescription drugs and controlled substances through prescription forgeries.

**8.19(3) Transmitting agent.** The prescriber may authorize an agent to transmit to the pharmacy a prescription drug order or medication order orally, by facsimile transmission, or by electronic transmission provided that the first and last names and title of the transmitting agent are included in the order.

   a. **New order.** A new written or electronically prepared and transmitted prescription drug or medication order shall be manually or electronically signed by the prescriber, except as provided in paragraph 8.19(1)“d.” If transmitted by the prescriber’s agent, the first and last names and title of the transmitting agent shall be included in the order. If the prescription is for a controlled substance and is written or printed from an electronic prescription application, the prescription shall be manually signed by the prescriber. An electronically prepared prescription shall not be electronically transmitted to the pharmacy if the prescription has been printed prior to the electronic transmission. An electronically prepared and electronically transmitted prescription that is printed following the electronic transmission shall be clearly labeled as a copy, not valid for dispensing.

   b. **Refill order or renewal order.** An authorization to refill a prescription drug or medication order, or to renew or continue an existing drug therapy, may be transmitted to professional pharmacy staff through oral communication, in writing, by facsimile transmission, or by electronic transmission initiated by or directed by the prescriber.

      (1) If the transmission is completed by the prescriber’s agent and the first and last names and title of the transmitting agent are included in the order, the prescriber’s signature is not required on the fax or alternate electronic transmission.

      (2) If the order differs in any manner from the original order, such as a change of the drug strength, dosage form, or directions for use, the prescriber shall sign the order as provided by paragraph 8.19(3)“a.”

**8.19(4) Receiving agent.** Regardless of the means of transmission to a pharmacy, only professional pharmacy staff shall be authorized to receive a new prescription drug or medication order from a prescriber or the prescriber’s agent. A technician trainee may receive a refill or renewal order from a prescriber or the prescriber’s agent only if the technician’s supervising pharmacist has authorized that function.

**8.19(5) Legitimate purpose.** The pharmacy and professional pharmacy staff shall ensure that the prescription drug or medication order, regardless of the means of transmission, has been issued for a legitimate medical purpose by a prescriber acting in the usual course of the prescriber’s professional
practice. A pharmacist shall not dispense a prescription drug if the pharmacist knows or should have known that the prescription was issued solely on the basis of an Internet-based questionnaire.

**8.19(6) Refills.** A refill is one or more dispensings of a prescription drug or device that result in the patient’s receipt of the quantity authorized by the prescriber for a single fill as indicated on the prescription drug order.

a. **Noncontrolled prescription drug or device.** A prescription for a prescription drug or device that is not a controlled substance may authorize no more than 12 refills within 18 months following the date on which the prescription is issued.

b. **Controlled substance.** A prescription for a Schedule III, IV, or V controlled substance may authorize no more than 5 refills within 6 months following the date on which the prescription is issued.

**8.19(7) Epinephrine auto-injector prescription issued to school or facility.** A physician, an advanced registered nurse practitioner, or a physician assistant may issue a prescription for one or more epinephrine auto-injectors in the name of a facility as defined in Iowa Code subsection 135.185(1), a school district, or an accredited nonpublic school. The prescription shall comply with all requirements of subrule 8.19(1) as applicable to the form of the prescription except that the prescription shall be issued in the name and address of the facility, the school district, or the accredited nonpublic school in lieu of the name and address of a patient. Provisions requiring a preexisting patient-prescriber relationship shall not apply to a prescription issued pursuant to this subrule.

a. The pharmacy’s patient profile and record of dispensing of a prescription issued pursuant to this subrule shall be maintained in the name of the facility, school district, or accredited nonpublic school to which the prescription was issued and the drug was dispensed.

b. The label affixed to an epinephrine auto-injector dispensed pursuant to this subrule shall identify the name of the facility, school district, or accredited nonpublic school to which the prescription is dispensed.

**8.19(8) Opioid antagonist prescription issued to law enforcement, fire department, or service program.** A physician, an advanced registered nurse practitioner, or a physician assistant may issue a prescription for one or more opioid antagonists in the name of a law enforcement agency, fire department, or service program pursuant to Iowa Code section 147A.18 and rule 657—39.7(135.147A). The prescription shall comply with all requirements of subrule 8.19(1) as applicable to the form of the prescription except that the prescription shall be issued in the name and address of the law enforcement agency, fire department, or service program in lieu of the name and address of a patient. Provisions requiring a preexisting patient-prescriber relationship shall not apply to a prescription issued pursuant to this subrule.

a. The pharmacy’s patient profile and record of dispensing of an opioid antagonist pursuant to this subrule shall be maintained in the name of the law enforcement agency, fire department, or service program to which the prescription was issued and the drug was dispensed.

b. The label affixed to an opioid antagonist dispensed pursuant to this subrule shall identify the name of the law enforcement agency, fire department, or service program to which the prescription is dispensed and shall be affixed such that the expiration date of the drug is not rendered illegible.

[ARC 8171B, IAB 9/23/09, effective 10/28/09; ARC 9912B, IAB 12/14/11, effective 1/18/12; ARC 2414C, IAB 2/17/16, effective 3/23/16; ARC 2827C, IAB 11/23/16, effective 11/3/16; ARC 3858C, IAB 6/20/18, effective 7/25/18; ARC 4580C, IAB 7/31/19, effective 9/4/19]

**657—8.20(155A) Valid prescriber/patient relationship.** Prescription drug orders and medication orders shall be valid as long as a prescriber/patient relationship exists. Once the prescriber/patient relationship is broken and the prescriber is no longer available to treat the patient or oversee the patient’s use of a prescription drug, any remaining prescription refills may be dispensed at the discretion of the pharmacist for a suitable amount of time so that the patient can establish care with a new provider and a new order can be issued. In determining the duration of which prescriptions may be dispensed, the pharmacist shall consider the patient’s health care status and access to health care services.

[ARC 3639C, IAB 2/14/18, effective 5/21/18]
657—8.21(155A) Prospective drug use review. For purposes of promoting therapeutic appropriateness and ensuring rational drug therapy, a pharmacist shall review the patient record, information obtained from the patient, and each prescription drug or medication order to identify:

1. Overutilization or underutilization;
2. Therapeutic duplication;
3. Drug-disease contraindications;
4. Drug-drug interactions;
5. Incorrect drug dosage or duration of drug treatment;
6. Drug-allergy interactions;
7. Clinical abuse/misuse;

Upon recognizing any of the above, the pharmacist shall take appropriate steps to avoid or resolve the problem and shall, if necessary, include consultation with the prescriber. The review and assessment of patient records shall not be delegated to pharmacy technicians or pharmacy support persons but may be delegated to registered pharmacist-interns under the direct supervision of the pharmacist.

[ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—8.22(155A) Notification of interchangeable biological product selection. Pursuant to Iowa Code section 155A.32, when a pharmacist substitutes a biological product that is an interchangeable biological product for the biological product prescribed, the pharmacist or pharmacist’s designee shall, within five business days of dispensing the biological product, communicate to the prescriber the name and manufacturer of the biological product dispensed unless the prescription information has been entered into an electronic record system, such as an electronic medical record, electronic prescribing system, pharmacy benefit management system, or a pharmacy record to which the prescriber has access. The manner of communication to the prescriber may be via telephone, facsimile, electronic transmission, or other prevailing means.

This rule is intended to implement Iowa Code section 155A.32.

[ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—8.23(124,155A) Individuals qualified to administer. Any person specifically authorized under pertinent sections of the Iowa Code to administer prescription drugs shall construe nothing in this rule to limit that authority. The board designates the following as qualified individuals to whom a prescriber may delegate the administration of prescription drugs.

1. Persons who have successfully completed a medication administration course.
2. Licensed pharmacists.

This rule is intended to implement Iowa Code section 155A.44.

[ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—8.24(155A) Documented verification. The pharmacist shall provide, document, and retain a record of the final verification for the accuracy, validity, completeness, and appropriateness of the patient’s prescription or medication order prior to the delivery of the medication to the patient or the patient’s representative. In an approved tech-check-tech program, the checking technician shall provide, document, and retain a record of the final verification for the accuracy of the patient’s prescription or medication order prior to the delivery of the medication to the patient or the patient’s representative.

[ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—8.25 Reserved.

657—8.26(155A) Continuous quality improvement program. Pursuant to rule 657—8.3(155A), each pharmacy licensed to provide pharmaceutical services to patients in Iowa shall implement or participate in a continuous quality improvement program (CQI program). The CQI program is intended to be an ongoing, systematic program of standards and procedures to detect, identify, evaluate, and prevent medication errors, thereby improving medication therapy and the quality of patient care. A pharmacy
that participates as an active member of a hospital or corporate CQI program that meets the objectives of this rule shall not be required to implement a new program pursuant to this rule.

8.26(1) Reportable program events. For purposes of this rule, a reportable program event or program event means a preventable medication error resulting in the incorrect dispensing of a prescribed drug received by or administered to the patient and includes but is not necessarily limited to:

a. An incorrect drug;
b. An incorrect drug strength;
c. An incorrect dosage form;
d. A drug received by the wrong patient;
e. Inadequate or incorrect packaging, labeling, or directions; or
f. Any incident related to a prescription dispensed to a patient that results in or has the potential to result in serious harm to the patient.

8.26(2) Responsibility. The pharmacist in charge may delegate program administration and monitoring, but the pharmacist in charge maintains ultimate responsibility for the validity and consistency of program activities.

8.26(3) Policies and procedures. Pursuant to rule 657—8.3(155A), each pharmacy shall have written policies and procedures for the operation and management of the pharmacy’s CQI program. A copy of the pharmacy’s CQI program description and policies and procedures shall be maintained and readily available to all pharmacy personnel. The policies and procedures shall address, at a minimum, a planned process to:

a. Train all pharmacy personnel in relevant phases of the CQI program;
b. Identify and document reportable program events;
c. Minimize the impact of reportable program events on patients;
d. Analyze data collected to assess the causes and any contributing factors relating to reportable program events;
e. Use the findings to formulate an appropriate response and to develop pharmacy systems and workflow processes designed to prevent and reduce reportable program events; and
f. Periodically, but at least quarterly, meet with appropriate pharmacy personnel to review findings and inform personnel of changes that have been made to pharmacy policies, procedures, systems, or processes as a result of CQI program findings.

8.26(4) Event discovery and notification. As provided by the procedures of the CQI program, the pharmacist in charge or appropriate designee shall be informed of and review all reported and documented program events. All pharmacy personnel shall be trained to immediately inform the pharmacist on duty of any discovered or suspected program event. When the pharmacist on duty determines that a reportable program event has occurred, the pharmacist shall ensure that all reasonably necessary steps are taken to remedy any problems or potential problems for the patient and that those steps are documented. Necessary steps include, but are not limited to, the following:

a. Notifying the patient or the patient’s caregiver and the prescriber or other members of the patient’s health care team as warranted;
b. Identifying and communicating directions or processes for correcting the error; and
c. Communicating instructions for minimizing any negative impact on the patient.

8.26(5) CQI program records. All CQI program records shall be maintained on site at the pharmacy or shall be accessible at the pharmacy and be available for inspection and copying by the board or its representative for at least two years from the date of the record. When a reportable program event occurs or is suspected to have occurred, the program event shall be documented in a written or electronic storage record created solely for that purpose. Records of program events shall be maintained in an orderly manner and shall be filed chronologically by date of discovery.

a. The program event shall initially be documented as soon as practicable but no more than three days following discovery of the event by the staff member who discovers the event or is informed of the event.
b. Program event documentation shall include a description of the event that provides sufficient information to permit categorization and analysis of the event and shall include:
(1) The date and time the program event was discovered and the name of the staff person who discovered the event; and
(2) The names of the individuals recording and reviewing or analyzing the program event information.

**8.26(6) Program event analysis and response.** The pharmacist in charge or designee shall review each reportable program event and determine if follow-up is necessary. When appropriate, information and data collected and documented shall be analyzed, individually and collectively, to assess the cause and any factors contributing to the program event. The analysis may include, but is not limited to, the following:

- A consideration of the effects on the quality of the pharmacy system related to workflow processes, technology utilization and support, personnel training, and both professional and technical staffing levels;
- Any recommendations for remedial changes to pharmacy policies, procedures, systems, or processes; and
- The development of a set of indicators that a pharmacy will utilize to measure its program standards over a designated period of time.

[ARC 1961C, IAB 4/15/15, effective 5/20/15; ARC 2413C, IAB 2/17/16, effective 3/23/16; ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—8.27 to 8.29Reserved.

657—8.30(126,155A) Sterile products. Rescinded IAB 6/6/07, effective 7/11/07.

657—8.31(135,147A) Opioid antagonist dispensing by pharmacists by standing order. Rescinded ARC 3858C, IAB 6/20/18, effective 7/25/18.

657—8.32(124,155A) Individuals qualified to administer. Rescinded ARC 3858C, IAB 6/20/18, effective 7/25/18.

657—8.33(155A) Vaccine administration by pharmacists. Rescinded ARC 3858C, IAB 6/20/18, effective 7/25/18.


657—8.35(155A) Pharmacy license. A pharmacy license issued by the board is required for all sites where prescription drugs are offered for sale or dispensed under the supervision of a pharmacist. The current pharmacy license certificate shall be displayed in a position visible to the public. The board may issue any of the following types of pharmacy licenses: a general pharmacy license, a hospital pharmacy license, a limited use pharmacy license, or a nonresident pharmacy license. Nonresident pharmacy license applicants shall comply with board rules regarding nonresident pharmacy practice except when a waiver has been granted. Applicants for general or hospital pharmacy practice shall comply with board rules regarding general or hospital pharmacy practice except when a waiver has been granted. Any pharmacy that dispenses controlled substances to Iowa residents must also register pursuant to 657—Chapter 10.

**8.35(1) Limited use pharmacy license.** A limited use pharmacy license may be issued for nuclear pharmacy practice, correctional facility pharmacy practice, veterinary pharmacy practice, telepharmacy practice, and other limited use practice settings. Applications for a limited use pharmacy license shall be considered on a case-by-case basis.

**8.35(2) Application.** Applicants for initial licensure, license renewal, license reactivation, or license changes pursuant to subrule 8.35(6) shall complete the relevant pharmacy license application and shall include all required information and attachments. All pharmacy license applications require submission of a nonrefundable $135 license fee plus applicable penalty fees. The application shall
include the signature of the pharmacy owner’s authorized representative and shall require at a minimum the following:
   a. Disclosure of pharmacy ownership information, including information about the pharmacy’s registered agent;
   b. Identification and signature of the pharmacist in charge;
   c. The identification of and average number of hours worked by all pharmacists, pharmacist-interns, pharmacy technicians, and pharmacy support persons working in the pharmacy;
   d. Criminal and disciplinary history information; and
   e. Description of the scope of services provided by the pharmacy.

8.35(3) License renewal. A pharmacy license shall be renewed before January 1 of each year. An initial pharmacy license issued between November 1 and December 31 shall not require renewal until the following calendar year. The nonrefundable fee for a timely license renewal shall be $135.
   a. Delinquent license grace period. A pharmacy license renewal application that is postmarked or hand-delivered to the board after January 1 but prior to February 1 following expiration shall be considered delinquent and shall require the nonrefundable payment of the renewal fee plus a penalty fee of $135. A pharmacy that submits a completed license renewal application, application fee, and penalty fee postmarked or delivered to the board office by January 31 shall not be subject to disciplinary action for continuing to operate in the month of January.
   b. Delinquent license reactivation beyond grace period. If a pharmacy license is not renewed prior to the expiration of the one-month grace period identified in paragraph 8.35(3)“a,” the pharmacy may not operate or provide pharmacy services to patients in the state of Iowa until the license is reactivated. A pharmacy without a current license may apply for license reactivation by submitting an application for reactivation and a nonrefundable $540 reactivation fee. As part of the reactivation application, the pharmacy shall disclose the prescriptions dispensed and the services, if any, that were provided to Iowa patients while the license was delinquent. A pharmacy that continues to operate or provide pharmacy services in Iowa without a current license may be subject to disciplinary sanctions.

8.35(4) Inspection of pharmacy location.
   a. A new pharmacy location in Iowa shall require an on-site inspection by an authorized agent of the board. Application for a pharmacy license and other required registrations shall be submitted to the board at least 14 days prior to the anticipated inspection. Any deficiencies identified during the inspection shall be corrected and verified by an authorized agent of the board prior to the issuance of the pharmacy license. Prescription drugs, including controlled substances, may not be delivered to a new pharmacy location prior to the delivery of the pharmacy license and registration certificates.
   b. A pharmacy location in Iowa which is applying for a different license type than previously held may be subject to an inspection prior to the issuance of the new license.

8.35(5) Failure to complete licensure. An application for a pharmacy license, including any other required registration applications, will become null and void if the applicant fails to complete the licensure process within six months of acceptance by the board of the required applications. The licensure process shall be complete upon the pharmacy’s opening for business at the licensed location following a satisfactory inspection by an agent of the board pursuant to this rule. When an applicant fails to timely complete the licensure process, fees submitted with applications will not be transferred or refunded. If the applicant intends to proceed with a pharmacy license, a new application and fee shall be required.

8.35(6) Pharmacy license changes. When a pharmacy changes its name, location, ownership, pharmacist in charge, or license type, a completed pharmacy license application with a nonrefundable $135 fee shall be submitted to the board pursuant to subrule 8.35(2). Upon receipt of the completed application and fee, the board shall issue an updated pharmacy license certificate, pending any necessary inspection pursuant to paragraph 8.35(4)“b,” unless the board identifies any ground for denial of the license. Any restrictions or disciplinary history associated with the previous pharmacy shall remain unchanged. A pharmacy wishing to disassociate itself from the previously licensed pharmacy restrictions or disciplinary history may petition the board for such disassociation. The burden is on the pharmacy to demonstrate that the current pharmacy is not associated with or responsible for the
pharmacy as it previously existed. The old license certificate shall be returned to the board within ten days of receiving the updated license certificate.

a. Name. A change of the name under which the pharmacy is doing business shall require submission of a pharmacy license application and appropriate fee prior to the change of name.

b. Location. A change of pharmacy location shall require submission of a pharmacy license application and appropriate fee prior to the change of location. A pharmacy undergoing a change in location is required to notify patients of the change in accordance with paragraph 8.35(7)"d." A change of pharmacy location in Iowa may require an on-site inspection of the new location as provided in subrule 8.35(4).

c. Ownership. A change in ownership of a pharmacy shall require submission of a pharmacy license application and appropriate fee prior to the change in ownership. A change of ownership occurs when the owner listed on the pharmacy’s most recent application changes or when there is a change affecting the majority ownership interest of the owner listed on the pharmacy’s most recent pharmacy application. A pharmacy undergoing a change in ownership is required to notify the pharmacist in charge and patients of the change in accordance with subrule 8.35(7). A change of ownership effectively consists of closing a pharmacy and opening a new pharmacy.

d. Pharmacist in charge. In addition to the requirements of this paragraph, a change of pharmacist in charge for a nonresident pharmacist shall require registration of the new permanent pharmacist in charge if the pharmacist in charge is not currently registered by the board or licensed to practice pharmacy in Iowa.

(1) If a permanent pharmacist in charge has been identified by the time of the vacancy, a pharmacy license application identifying the new pharmacist in charge, along with the appropriate fee, shall be submitted to the board within ten days of the change.

(2) If a permanent pharmacist in charge has not been identified by the time of the vacancy, a temporary pharmacist in charge shall be identified. Written notification identifying the temporary pharmacist in charge shall be submitted to the board within ten days of the vacancy.

(3) If a permanent pharmacist in charge was not identified within ten days of the vacancy, the pharmacy shall, within 90 days of the vacancy, identify a permanent pharmacist in charge. A pharmacy license application identifying the permanent pharmacist in charge, along with appropriate fee, shall be submitted to the board within ten days of the appointment of a permanent pharmacist in charge. The pharmacy license application and the pharmacist in charge registration application, if needed, including appropriate fees, shall be received by the board within 90 days of the original vacancy of the permanent pharmacist in charge position.

e. License type. A change in pharmacy license type shall require submission of a pharmacy license application and appropriate fee prior to the change in license type. A pharmacy changing license type shall notify the pharmacist in charge and patients of the change in accordance with subrule 8.35(7).

f. License change application submission. An application for license change shall be timely submitted pursuant to this subrule. A licensed pharmacy that has timely submitted an application for license change and fee may continue to service Iowa patients while the license change is pending final approval. An applicant who has submitted an application for license change after the required date of submission pursuant to this subrule but within 30 days of the required date of submission shall be assessed a nonrefundable late penalty fee of $135 in addition to the license fee. An applicant who has submitted an application for license change 31 days or later following the required date of submission pursuant to this subrule shall be assessed a nonrefundable late penalty fee of $540.

8.35(7) Closing or sale of a pharmacy. A closing pharmacy shall ensure that all pharmacy records are transferred to another licensed pharmacy that agrees to act as custodian of the records for at least two years. A pharmacy shall not execute a sale or closing of a pharmacy unless there exists an adequate period of time prior to the pharmacy’s closing for delivery of the notifications to the pharmacist in charge, the board, the DEA, and pharmacy patients as required by this subrule. However, the provisions of this subrule regarding prior notifications to the board, the DEA, and patients shall not apply in the case of a board-approved emergency or unforeseeable closure, including but not limited to emergency board action, foreclosure, fire, or natural disaster.
a. **Pharmacist in charge notification.** At least 40 days prior to the effective date of the sale or closing of a pharmacy, the pharmacist in charge of the closing pharmacy shall be notified of the proposed sale or closing. Information regarding the pending sale or closure of the pharmacy may be kept confidential until public notifications, which are required 30 days prior to the pharmacy’s closing, are made. The pharmacist in charge of the closing pharmacy shall provide input and direction to the pharmacy owner regarding the responsibilities of the closing pharmacy, including the notifications, deadlines, and timelines established by this subrule. The pharmacist in charge of the purchasing or receiving pharmacy shall be notified of the pending transaction at least 30 days prior to the sale or closure of the pharmacy.

b. **Board and DEA notifications.** At least 30 days prior to the closing of a pharmacy, a written notice shall be sent to the board. Notification to the DEA shall be pursuant to federal regulation. Notification to the board shall include:

   1. The anticipated date of closing or transfer of prescription drugs or records.
   2. The name, address, DEA registration number, Iowa pharmacy license number, and Iowa controlled substances Act (CSA) registration number of the closing pharmacy and of the pharmacy to which prescription drugs will be transferred.
   3. The name, address, DEA registration number, Iowa pharmacy license number, and CSA registration number of the location at which records will be maintained.

c. **Terms of sale or purchase.** If the closing is due to the sale of the pharmacy, a copy of the sale or purchase agreement, not including information regarding the monetary terms of the transaction, shall be submitted to the board upon the request of the board. The agreement shall include a written assurance from the closing pharmacy to the purchasing pharmacy that the closing pharmacy has given or will be giving notice to its patients as required by this subrule.

d. **Patient notification.** At least 30 days prior to closing, a closing pharmacy shall make a reasonable effort to notify all patients who had a prescription filled by the closing pharmacy within the last 18 months that the pharmacy intends to close, including the anticipated closing date.

   1. Written notification shall identify the pharmacy that will be receiving the patient’s records. The notification shall advise patients that all patient records will be transferred to the identified pharmacy and that patients may contact the closing pharmacy to request the transfer of remaining refills to a pharmacy of the patient’s choice. The notification shall also advise patients that after the date of closing, patients may contact the pharmacy to which the records have been transferred.
   2. Written notification shall be delivered to each patient at the patient’s last address on file with the closing pharmacy by direct mail or personal delivery. A pharmacy shall not be required to provide written notice to more than one patient within the same household.
   3. Public notice shall be provided in a location and manner clearly visible to patients in the pharmacy pickup locations including drive-through prescription pickup lanes, on pharmacy or retail store entry and exit doors, and at pharmacy prescription counters.

e. **Patient communication by receiving pharmacy.** A pharmacy receiving the patient records of another pharmacy shall not contact the patients of the closing pharmacy until after the transfer of those patient records from the closing pharmacy to the receiving pharmacy and after the closure of the closing pharmacy.

f. **Prescription drug inventory.** A complete inventory of all prescription drugs being transferred shall be taken as of the close of business. The inventory shall serve as the ending inventory for the closing pharmacy as well as a record of additional or starting inventory for the pharmacy to which the drugs are transferred. A copy of the inventory shall be maintained in the records of the purchasing pharmacy for at least two years.

   1. DEA Form 222 is required for transfer of Schedule II controlled substances.
   2. The inventory of controlled substances shall be completed pursuant to the requirements in rule 657—10.19(124).
   3. The inventory of all noncontrolled prescription drugs shall include the name, strength, dosage form, and quantity, which may be estimated.
(4) Controlled substances and prescription drugs requiring destruction or other disposal shall be transferred in the same manner as all other drugs. The new owner is responsible for the disposal of these drugs.

\[\text{ARC } 8673B, \text{ IAB } 4/7/10, \text{ effective } 6/1/10; \text{ ARC } 9526B, \text{ IAB } 6/1/11, \text{ effective } 7/6/11 \text{ (See Delay note at end of chapter); } \text{ARC } 9693B, \text{ IAB } 9/7/11, \text{ effective } 8/11/11; \text{ ARC } 0504C, \text{ IAB } 12/12/12, \text{ effective } 1/16/13; \text{ ARC } 1962C, \text{ IAB } 4/15/15, \text{ effective } 5/20/15; \text{ARC } 3236C, \text{ IAB } 8/2/17, \text{ effective } 9/6/17; \text{ ARC } 3345C, \text{ IAB } 9/27/17, \text{ effective } 11/1/17; \text{ ARC } 3858C, \text{ IAB } 6/20/18, \text{ effective } 7/25/18; \text{ARC } 4268C, \text{ IAB } 1/30/19, \text{ effective } 3/6/19\]

657—8.36 to 8.39 Reserved.

657—8.40(155A.84GA, ch63) Pharmacy pilot or demonstration research projects. Rescinded ARC 3858C, IAB 6/20/18, effective 7/25/18.

These rules are intended to implement Iowa Code sections 124.101, 124.301, 124.306, 124.308, 126.10, 126.11, 126.16, 135C.33, 147.7, 147.55, 147.72, 147.74, 147.76, 155A.2 through 155A.4, 155A.6, 155A.10, 155A.12 through 155A.15, 155A.19, 155A.20, 155A.27 through 155A.29, 155A.31 through 155A.35, and 155A.41.

[Filed 4/11/68; amended 11/14/73]
[Filed 11/24/76, Notice 10/20/76—published 12/15/76, effective 1/19/77]
[Filed 11/9/77, Notice 10/5/77—published 11/30/77, effective 1/4/78]
[Filed emergency 12/9/77—published 12/28/77, effective 12/9/77]
[Filed 10/20/78, Notice 8/9/78—published 11/15/78, effective 1/9/79]
[Filed 12/2/78, Notice 11/15/78—published 1/10/79, effective 2/14/79]
[Filed 12/21/78, Notice 11/15/78—published 1/10/79, effective 2/14/79]
[Filed 12/7/79, Notice 10/3/79—published 12/26/79, effective 1/30/80]
[Filed emergency 4/22/80—published 5/14/80, effective 4/22/80]
[Filed 12/1/80, Notice 10/15/80—published 12/24/80, effective 1/28/81]
[Filed 2/12/81, Notice 12/24/80—published 3/4/81, effective 4/8/81]
[Filed 5/27/81, Notice 4/1/81—published 6/24/81, effective 7/29/81]
[Filed emergency 7/28/81—published 8/19/81, effective 8/1/81]
[Filed emergency 9/14/81—published 9/30/81, effective 9/30/81]
[Filed 7/28/82, Notice 3/17/82—published 8/18/82, effective 9/22/82]
[Filed emergency 8/26/82—published 9/15/82, effective 9/22/82]
[Filed 9/10/82, Notice 6/9/82—published 9/29/82, effective 11/8/82]
[Filed emergency 10/6/82—published 10/27/82, effective 10/27/82]
[Filed emergency 12/2/82—published 12/22/82, effective 12/22/82]
[Filed 11/18/83, Notice 8/3/83—published 12/7/83, effective 1/11/84]
[Filed 1/13/84, Notice 11/9/83—published 2/1/84, effective 3/7/84]
[Filed 6/22/84, Notice 4/11/84—published 7/18/84, effective 8/22/84]
[Filed emergency 7/13/84—published 8/1/84, effective 7/13/84]
[Filed 9/21/84, Notice 7/18/84—published 10/10/84, effective 11/14/84]
[Filed 2/22/85, Notice 11/21/84—published 3/13/85, effective 4/18/85]
[Filed emergency 6/18/85—published 7/3/85, effective 7/1/85]
[Filed 8/30/85, Notice 7/3/85—published 9/25/85, effective 10/30/85]
[Filed 11/27/85, Notice 8/28/85—published 12/18/85, effective 1/22/86]
[Filed 9/19/86, Notice 6/4/86—published 10/8/86, effective 11/12/86]
[Filed 1/28/87, Notice 11/19/86—published 2/25/87, effective 4/1/87]
[Filed emergency 1/21/88—published 2/10/88, effective 1/22/88]
[Filed 1/21/88, Notice 11/4/87—published 2/10/88, effective 3/16/88]
[Filed 11/17/88, Notice 8/24/88—published 12/14/88, effective 1/18/89]
[Filed emergency 5/16/89—published 6/14/89, effective 5/17/89]
[Filed 12/26/89, Notice 10/4/89—published 1/24/90, effective 2/28/90]
[Filed 3/19/90, Notice 1/10/90—published 4/18/90, effective 5/23/90]
[Filed 8/31/90, Notice 6/13/90—published 9/19/90, effective 10/24/90]
[Filed 1/29/91, Notice 6/13/90—published 2/20/91, effective 3/27/91]
[Filed 1/29/91, Notice 9/19/90—published 2/20/91, effective 3/27/91]
[Filed 4/26/91, Notice 2/20/91—published 5/15/91, effective 6/19/91]
[Filed emergency 5/10/91—published 5/29/91, effective 5/10/91]
[Filed 7/30/91, Notice 5/29/91—published 8/21/91, effective 9/25/91]
[Filed 1/21/92, Notice 10/16/91—published 2/19/92, effective 3/25/92]
[Filed 3/12/92, Notice 1/8/92—published 4/1/92, effective 5/6/92]
[Filed 5/21/92, Notice 4/1/92—published 6/10/92, effective 7/15/92]
[Filed 10/22/92, Notice 9/2/92—published 11/11/92, effective 1/1/93]
[Filed 9/23/93, Notice 5/26/93—published 10/13/93, effective 11/17/93]
[Filed 3/22/95, Notice 11/9/94—published 4/12/95, effective 5/31/95]
[Filed 10/6/95, Notices 6/7/95, 8/16/95—published 10/25/95, effective 1/1/96]
[Filed emergency 12/14/95—published 1/3/96, effective 1/1/96]
[Filed 12/10/96, Notice 8/28/96—published 1/1/97, effective 2/5/97]
[Filed 2/27/97, Notice 8/28/96—published 3/26/97, effective 4/30/97]
[Filed 2/27/97, Notice 1/1/97—published 3/26/97, effective 4/30/97]
[Filed 6/23/97, Notice 3/26/97—published 7/16/97, effective 8/20/97]
[Filed 11/19/97, Notice 10/8/97—published 12/17/97, effective 1/21/98]
[Filed 7/31/98, Notice 5/20/98—published 8/26/98, effective 10/15/98]
[Filed 11/23/99, Notice 6/2/99—published 12/15/99, effective 1/19/00]
[Filed 2/18/00, Notice 12/15/99—published 3/22/00, effective 4/26/00]
Filed 11/9/00, Notice 4/19/00—published 11/29/00, effective 1/3/01
Filed 8/14/02, Notice 6/12/02—published 9/4/02, effective 10/9/02
Filed 3/11/04, Notice 8/6/03—published 3/31/04, effective 5/5/04
Filed emergency 7/16/04 after Notice 6/9/04—published 8/4/04, effective 7/16/04
Filed 10/22/04, Notice 3/31/04—published 11/10/04, effective 12/15/04
Filed 10/22/04, Notice 5/12/04—published 11/10/04, effective 12/15/04
Filed 6/2/05, Notice 3/16/05—published 6/22/05, effective 7/27/05
Filed emergency 6/30/05 after Notice 5/11/05—published 7/20/05, effective 7/1/05
Filed 3/22/06, Notice 1/18/06—published 4/12/06, effective 5/17/06
Filed 5/17/06, Notice 4/12/06—published 6/7/06, effective 7/12/06
Filed 5/17/06, Notice 2/15/06—published 6/7/06, effective 10/1/06
Filed 11/30/06, Notice 9/27/06—published 12/20/06, effective 1/24/07
Filed 2/7/07, Notice 10/25/06—published 2/28/07, effective 4/4/07
Filed 5/14/07, Notice 2/28/07—published 6/6/07, effective 7/11/07
Filed 8/3/07, Notice 5/9/07—published 8/29/07, effective 10/3/07
Filed 8/3/07, Notice 6/20/07—published 8/29/07, effective 10/3/07
Filed emergency 11/13/07 after Notice 8/29/07—published 12/5/07, effective 11/13/07
Filed 11/13/07, Notice 8/29/07—published 12/5/07, effective 1/9/08
Filed 5/19/08, Notice 3/26/08—published 6/18/08, effective 7/23/08
Filed 9/5/08, Notice 7/2/08—published 9/24/08, effective 10/29/08
Filed ARC 7636B (Notice ARC 7448B, IAB 12/31/08, IAB 3/11/09, effective 4/15/09
Filed ARC 8171B (Notice ARC 7910B, IAB 7/1/09, IAB 9/23/09, effective 10/28/09
Filed ARC 8539B (Notice ARC 8269B, IAB 11/4/09, IAB 2/24/10, effective 4/1/10
Filed ARC 8673B (Notice ARC 8380B, IAB 12/16/09, IAB 4/7/10, effective 6/1/10
Filed ARC 8671B (Notice ARC 8414B, IAB 12/30/09, IAB 4/7/10, effective 5/12/10
Filed ARC 9409B (Notice ARC 9194B, IAB 11/3/10, IAB 3/9/11, effective 4/13/11
Filed ARC 9526B (Notice ARC 9295B, IAB 12/29/10, IAB 6/1/11, effective 7/6/11
[Editorial change: IAC Supplement 6/29/11]
Filed Emergency ARC 9693B, IAB 9/7/11, effective 8/11/11
Filed ARC 9912B (Notice ARC 9671B, IAB 8/10/11, IAB 12/14/11, effective 1/18/12
Filed ARC 0393C (Notice ARC 0256C, IAB 8/8/12, IAB 10/17/12, effective 11/21/12
Filed ARC 0503C (Notice ARC 0371C, IAB 10/3/12, IAB 12/12/12, effective 1/16/13
Filed ARC 0504C (Notice ARC 0351C, IAB 10/3/12, IAB 12/12/12, effective 1/16/13
Filed Emergency After Notice ARC 1030C (Notice ARC 0883C, IAB 7/24/13, IAB 9/18/13, effective 9/1/13
Filed ARC 1032C (Notice ARC 0882C, IAB 7/24/13, IAB 9/18/13, effective 10/23/13
Filed ARC 1576C (Notice ARC 1411C, IAB 4/2/14, IAB 8/20/14, effective 9/24/14
Filed ARC 1786C (Notice ARC 1652C, IAB 10/1/14, IAB 12/10/14, effective 1/14/15
Filed ARC 1961C (Notice ARC 1793C, IAB 12/10/14, IAB 4/15/15, effective 5/20/15
Filed ARC 1962C (Notice ARC 1792C, IAB 12/10/14, IAB 4/15/15, effective 5/20/15
Filed ARC 2408C (Notice ARC 2285C, IAB 12/9/15, IAB 2/17/16, effective 3/23/16
Filed ARC 2413C (Notice ARC 2307C, IAB 12/9/15, IAB 2/17/16, effective 3/23/16
Filed ARC 2414C (Notice ARC 2288C, IAB 12/9/15, IAB 2/17/16, effective 3/23/16
Filed Emergency After Notice ARC 2827C (Notice ARC 2721C, IAB 9/28/16, IAB 11/23/16, effective 11/3/16
Filed ARC 3236C (Notice ARC 3037C, IAB 4/26/17, IAB 8/2/17, effective 9/6/17
Filed ARC 3345C (Notice ARC 3136C, IAB 6/21/17, IAB 9/27/17, effective 11/1/17
Filed ARC 3639C (Notice ARC 3371C, IAB 10/11/17, IAB 2/14/18, effective 3/21/18
Filed ARC 3858C (Notice ARC 3509C, IAB 12/20/17, IAB 6/20/18, effective 7/25/18
Filed ARC 4267C (Notice ARC 4029C, IAB 9/26/18, IAB 1/30/19, effective 3/6/19
Filed ARC 4268C (Notice ARC 4092C, IAB 10/24/18, IAB 1/30/19, effective 3/6/19
[Filed ARC 4454C (Amended Notice ARC 4172C, IAB 12/19/18; Notice ARC 3978C, IAB 8/29/18), IAB 5/22/19, effective 6/26/19]

[Filed ARC 4580C (Notice ARC 4386C, IAB 4/10/19), IAB 7/31/19, effective 9/4/19]

◊ Two or more ARCs

July 6, 2011, effective date of 8.35(7) delayed 70 days by the Administrative Rules Review Committee at its meeting held June 14, 2011.
CHAPTER 10
CONTROLLED SUBSTANCES
[Prior to 2/10/88, see Pharmacy Examiners[620] Ch 8]

657—10.1(124) Purpose and scope. This chapter establishes the minimum standards for any activity that involves controlled substances. Any person or business that manufactures; distributes; dispenses; prescribes; conducts instructional activities, research, or chemical analysis with; or imports or exports controlled substances listed in Schedules I through V of Iowa Code chapter 124 in or into the state of Iowa, or that proposes to engage in such activities, shall obtain and maintain a registration issued by the board unless exempt from registration pursuant to rule 657—10.8(124). A person or business required to be registered shall not engage in any activity for which registration is required until the application for registration is granted and the board has issued a certificate of registration to such person or business. A registration is not transferable to any person or business.
[ARC 3345C, IAB 9/27/17, effective 11/1/17]

657—10.2(124) Definitions. For the purposes of this chapter, the following definitions shall apply:

“Authorized collection program” means a program administered by a registrant that has modified its registration with DEA to collect controlled substances for the purpose of disposal. Federal regulations for such programs can be found at www.deadiversion.usdoj.gov/drug_disposal/. Modification to the registrant’s Iowa controlled substances Act registration shall not be required.

“Board” means the Iowa board of pharmacy.

“CSA” means the Iowa uniform controlled substances Act.

“CSA registration” or “registration” means the registration issued by the board pursuant to the CSA that signifies the registrant’s authorization to engage in registered activities with controlled substances.

“DEA” means the United States Department of Justice, Drug Enforcement Administration.

“Individual practitioner” means a physician or surgeon (M.D.), osteopathic physician or surgeon (D.O.), dentist (D.D.S. or D.M.D.), doctor of veterinary medicine (D.V.M.), podiatric physician (D.P.M.), optometrist (O.D.), physician assistant (P.A.), resident physician, advanced registered nurse practitioner (A.R.N.P.), or prescribing psychologist.

“Prescription monitoring program,” “PMP,” or “program” means the program established pursuant to 657—Chapter 37 for the collection and maintenance of PMP information and for the provision of PMP information to authorized individuals.
[ARC 3345C, IAB 9/27/17, effective 11/1/17; ARC 4455C, IAB 5/22/19, effective 6/26/19]

657—10.3(124) Who shall register. The following persons or businesses shall register on forms provided by the board:

1. Manufacturers, distributors, importers, and exporters located in Iowa. Effective January 1, 2018, nonresident manufacturers, distributors, importers, and exporters distributing controlled substances into Iowa.
2. Reverse distributors located in Iowa. Effective January 1, 2018, nonresident reverse distributors engaging in the transfer of controlled substances with registrants located in Iowa.
3. Individual practitioners located in Iowa who are administering, dispensing, or prescribing controlled substances and individual practitioners located outside of Iowa who are dispensing or prescribing controlled substances via telehealth services to patients located in Iowa.
4. Pharmacies located in Iowa that are dispensing controlled substances. Effective January 1, 2018, pharmacies located outside of Iowa that are delivering controlled substances to patients located in Iowa.
5. Hospitals located in Iowa that are administering or dispensing controlled substances. Effective January 1, 2018, hospitals located outside of Iowa that are administering or dispensing controlled substances to patients located in Iowa.
6. Emergency medical service programs that are administering controlled substances to patients located in Iowa.
7. Care facilities that are located in Iowa.
8. Researchers, analytical laboratories, and teaching institutions that are located in Iowa.
9. Animal shelters and dog training facilities that are located in Iowa.
[ARC 3345C, IAB 9/27/17, effective 11/1/17]

657—10.4 Reserved.

657—10.5(124) Application. Applicants for initial registration, registration renewal pursuant to rule 657—10.6(124), or modifications pursuant to rule 657—10.9(124) shall complete the appropriate application and shall include all required information and attachments.

10.5(1) Signature requirements. Each application, attachment, or other document filed as part of an application shall be signed by the applicant as follows:
   a. If the applicant is an individual practitioner, the practitioner shall sign the application and supporting documents.
   b. If the applicant is a business, the application and supporting documents shall be signed by the person ultimately responsible for the security and maintenance of controlled substances at the registered location. If the applicant is a pharmacy, the responsible individual shall be the pharmacist in charge, unless the applicant petitions the board for an alternate responsible individual.

10.5(2) Prescribing practitioner PMP registration required. A prescribing practitioner, except for a licensed veterinarian, shall register for the PMP at the same time the prescribing practitioner applies for registration.

10.5(3) Registration fee exemptions. The registration fee is waived for federal, state, and local law enforcement agencies and for the following federal and state institutions: hospitals, health care or teaching institutions, and analytical laboratories authorized to possess, manufacture, distribute, and dispense controlled substances in the course of official duties. In order to enable law enforcement agency laboratories to obtain and transfer controlled substances for use as standards in chemical analysis, such laboratories shall maintain a registration to conduct chemical analysis (analytical laboratory). Such laboratories shall be exempt from any registration fee. Exemption from payment of any fees as provided in this subrule does not relieve the entity of registration or of any other requirements or duties prescribed by law.

10.5(4) Fees. Each application shall include a nonrefundable registration fee, except as provided in subrule 10.5(3), of $90 per biennium, which may be prorated to the expiration date of the applicant’s underlying professional license or other board license if applicable, and may include a nonrefundable surcharge of not more than 25 percent of the registration fee for deposit into the program fund.
[ARC 3345C, IAB 9/27/17, effective 11/1/17; ARC 4455C, IAB 5/22/19, effective 6/26/19]

657—10.6(124) Registration renewal. Each registrant shall be renewed prior to its expiration. A registrant may renew its registration up to 60 days prior to the registration expiration. The nonrefundable fee for registration renewal shall be $90 per biennium and may include a nonrefundable surcharge of not more than 25 percent of the registration fee for deposit into the program fund.

10.6(1) Delinquent registration grace period. A registration renewal application that is submitted after expiration but within 30 days following expiration shall be considered delinquent and shall require the nonrefundable payment of the application fee plus a nonrefundable late penalty fee of $90 and may require payment of a surcharge of not more than 25 percent of the applicable fees for deposit into the program fund. A registrant that submits a completed registration renewal application, nonrefundable late application fee, and nonrefundable late penalty fee within 30 days following expiration shall not be subject to disciplinary action for continuing to operate in the 30 days following expiration.

10.6(2) Delinquent registration reactivation beyond grace period. If a registration renewal application is not postmarked or hand-delivered to the board office within 30 days following the registration’s expiration date, the registrant may not conduct operations that involve controlled substances until the registrant reactivates the registration. A registrant may apply for reactivation by submitting a registration application for reactivation. The nonrefundable fee for reactivation shall be $360 and may include a nonrefundable surcharge of not more than 25 percent of the applicable fee for deposit into the program fund. As part of the reactivation application, the registrant shall disclose
the activities conducted with respect to controlled substances while the registration was expired. A registrant that continues to conduct activities with respect to controlled substances without an active registration may be subject to disciplinary sanctions. [ARC 3345C, IAB 9/27/17, effective 11/1/17; ARC 4455C, IAB 5/22/19, effective 6/26/19]

657—10.7(124) Separate registration for independent activities; coincident activities. The following activities are deemed to be independent of each other and shall require separate registration. Any person or business engaged in more than one of these activities shall be required to separately register for each independent activity, provided, however, that registration in an independent activity shall authorize the registrant to engage in activities identified coincident with that independent activity.

10.7(1) Manufacturing controlled substances. A person or business registered to manufacture controlled substances in Schedules I through V may distribute any substances for which registration to manufacture was issued. A person or business registered to manufacture controlled substances in Schedules II through V may conduct chemical analysis and preclinical research, including quality control analysis, with any substances listed in those schedules for which the person or business is registered to manufacture.

10.7(2) Distributing controlled substances. This independent activity includes the delivery, other than by administering or dispensing, of controlled substances listed in Schedules I through V. No coincident activities are authorized.

10.7(3) Dispensing, administering, prescribing, or instructing with controlled substances. These independent activities include, but are not limited to, prescribing, administering, and dispensing by individual practitioners; dispensing by pharmacies and hospitals; and conducting instructional activities with controlled substances listed in Schedules II through V. A person or business registered for these independent activities may conduct research and instructional activities with those substances for which the person or business is registered to the extent authorized under state law. If an entity that engages in the distribution, administration, dispensing, or storing of controlled substances maintains multiple licenses, such as a hospital that has both inpatient and outpatient pharmacies, a separate registration shall be maintained for each license.

10.7(4) Conducting research with controlled substances listed in Schedule I. A researcher may manufacture or import the substances for which registration was issued provided that such manufacture or import is permitted under the federal DEA registration. A researcher may distribute the substances for which registration was issued to persons or businesses registered or authorized to conduct research with that class of substances or registered or authorized to conduct chemical analysis with controlled substances.

10.7(5) Conducting research with controlled substances listed in Schedules II through V. A researcher may conduct chemical analysis with controlled substances in those schedules for which registration was issued, may manufacture such substances if and to the extent such manufacture is permitted under the federal DEA registration, and may import such substances for research purposes. A researcher may distribute controlled substances in those schedules for which registration was issued to persons registered or authorized to conduct chemical analysis, instructional activities, or research with such substances, and to persons exempt from registration pursuant to Iowa Code section 124.302(3), and may conduct instructional activities with controlled substances.

10.7(6) Conducting chemical analysis with controlled substances. A person or business registered to conduct chemical analysis with controlled substances listed in Schedules I through V may manufacture and import controlled substances for analytical or instructional activities; may distribute such substances to persons registered or authorized to conduct chemical analysis, instructional activities, or research with such substances and to persons exempt from registration pursuant to Iowa Code section 124.302(3); may export such substances to persons in other countries performing chemical analysis or enforcing laws relating to controlled substances or drugs in those countries; and may conduct instructional activities with controlled substances.
10.7(7) Importing or exporting controlled substances. A person or business registered to import controlled substances listed in Schedules I through V may distribute any substances for which such registration was issued.  
[ARC 3345C, IAB 9/27/17, effective 11/1/17]

657—10.8(124) Separate registrations for separate locations; exemption from registration. A separate registration is required for each principal place of business or professional practice location where controlled substances are manufactured, distributed, imported, exported, dispensed, stored, or collected for the purpose of disposal unless the person or business is exempt from registration pursuant to Iowa Code section 124.302(3), this rule, or federal regulations.

10.8(1) Warehouse. A warehouse where controlled substances are stored by or on behalf of a registered person or business shall be exempt from registration except as follows:

a. Registration of the warehouse shall be required if such controlled substances are distributed directly from that warehouse to registered locations other than the registered location from which the substances were delivered to the warehouse.

b. Registration of the warehouse shall be required if such controlled substances are distributed directly from that warehouse to persons exempt from registration pursuant to Iowa Code section 124.302(3).

10.8(2) Sales office. An office used by agents of a registrant where sales of controlled substances are solicited, made, or supervised shall be exempt from registration. Such office shall not contain controlled substances, except substances used for display purposes or for lawful distribution as samples, and shall not serve as a distribution point for filling sales orders.

10.8(3) Prescriber’s office. An office used by a prescriber who is registered at another location and where controlled substances are prescribed but where no supplies of controlled substances are maintained shall be exempt from registration. However, a prescriber who practices at more than one office location where controlled substances are administered or otherwise dispensed as a regular part of the prescriber’s practice shall register at each location wherein the prescriber maintains supplies of controlled substances.

10.8(4) Prescriber in hospital. A prescriber who is registered at another location and who treats patients and may order the administration of controlled substances in a hospital other than the prescriber’s registered practice location shall not be required to obtain a separate registration at the location of the hospital.

10.8(5) Affiliated interns, residents, or foreign physicians. An individual practitioner who is an intern, resident, or foreign physician may dispense and prescribe controlled substances under the registration of the hospital or other institution which is registered and by whom the practitioner is employed provided that:

a. The hospital or other institution by which the individual practitioner is employed has determined that the practitioner is permitted to dispense or prescribe drugs by the appropriate licensing board.

b. Such individual practitioner is acting only in the scope of employment or practice in the hospital, institution, internship program, or residency program.

c. The hospital or other institution authorizes the intern, resident, or foreign physician to dispense or prescribe under the hospital registration and designates a specific internal code number, letters, or combination thereof which shall be appended to the institution’s DEA registration number, preceded by a hyphen (e.g., AP1234567-10 or AP1234567-12).

d. The hospital or institution maintains a current list of internal code numbers identifying the corresponding individual practitioner, available for the purpose of verifying the authority of the prescribing individual practitioner.  
[ARC 3345C, IAB 9/27/17, effective 11/1/17]

657—10.9(124) Modification or termination of registration. A registered individual or business shall apply to modify a current registration as provided by this rule. When submission of an application and fee is required, such application and fee shall be timely submitted pursuant to rule 657—10.5(124). A registrant which has timely submitted an application for registration modification and fee may continue to service Iowa patients while the registration modification is pending final approval. A registrant which
has submitted an application for registration modification after the required date of submission pursuant
to this rule but within 30 days of the required date of submission shall be assessed a nonrefundable late
penalty fee of $90 in addition to the application fee. A registrant which has submitted an application for
registration modification 31 days or later following the required date of submission pursuant to this rule
shall be assessed a nonrefundable late penalty fee of $360.

10.9(1) Change of substances authorized. Any registrant shall apply to modify the substances
authorized by the registration by submitting a written request to the board. The request shall include the
registrant’s name, address, telephone number, registration number, and the substances or schedules to be
added to or removed from the registration and shall be signed by the same person who signed the most
recent application for registration or registration renewal. No fee shall be required for the modification.

10.9(2) Change of address of registered location.
  a. Individual practitioner or researcher. An entity registered as an individual practitioner or
researcher shall apply to change the address of the registered location by submitting a written request
to the board. The request shall include the registrant’s name, current address, new address, telephone
number, effective date of the address change, and registration number, and shall be signed by the
registered individual practitioner or the same person who signed the most recent application for
registration or registration renewal. No fee shall be required for the modification.
  b. Pharmacy, hospital, care facility, service program, manufacturer, distributor; analytical
laboratory, teaching institution, importer, or exporter. An entity registered as a pharmacy, hospital, care
facility, service program, manufacturer, distributor, analytical laboratory, teaching institution, importer,
or exporter shall apply to change the address of the registered location by submitting a completed
application and fee for registration as provided in rule 657—10.5(124). The registrant shall submit
a completed application and fee for change in registration simultaneously with any other required
application pursuant to the board’s rules for the applicable license or registration. In the absence of a
simultaneous license or registration application, the registrant shall submit a completed application and
fee for change in registration no less than 30 days in advance of the change of address.

10.9(3) Change of registrant’s name.
  a. Individual practitioner or researcher. An entity registered as an individual practitioner or
researcher shall apply to change the registrant’s name by submitting a written request to the board. The
request shall include the registrant’s current name, new name, address, telephone number, effective
date of the name change, and registration number, and shall be signed by the registered individual
practitioner or the same person who signed the most recent application for registration or registration
renewal. No fee shall be required for the modification. Change of name, as used in this paragraph,
refers to a change of the legal name of the registrant and does not authorize the transfer of a registration
issued to an individual practitioner or researcher to another individual practitioner or researcher.
  b. Pharmacy, hospital, care facility, service program, manufacturer, distributor; analytical
laboratory, teaching institution, importer, or exporter. An entity registered as a pharmacy, hospital, care
facility, service program, manufacturer, distributor, analytical laboratory, teaching institution, importer,
or exporter shall apply to change the registrant name by submitting a completed application and fee for
registration as provided in rule 657—10.5(124). The registrant shall submit a completed application and
fee for change in registration simultaneously with any other required application pursuant to the board’s
rules for the applicable license or registration. In the absence of a simultaneous license or registration
application, the registrant shall submit a completed application and fee for change in registration no
less than 30 days in advance of the change of registrant’s name.

10.9(4) Change of ownership of registered business entity. A change of immediate ownership of
a pharmacy, hospital, care facility, service program, manufacturer, distributor, analytical laboratory,
teaching institution, importer, or exporter shall require the submission of a completed application
and fee for registration as provided in rule 657—10.5(124). The registrant shall submit a completed
application and fee for change in registration simultaneously with any other required application
pursuant to the board’s rules for the applicable license or registration. In the absence of a simultaneous
license or registration application, the registrant shall submit a completed application and fee for change
in registration no less than 30 days in advance of the change of registrant’s ownership.
10.9(5) Change of responsible individual. Any registrant, except an individual practitioner or researcher or a pharmacy or hospital, shall apply to change the responsible individual authorized by the registration by submitting a written request to the board. The request shall include the registrant’s name, address, and telephone number; the name and title of the current responsible individual and of the new responsible individual; the effective date of the change; and the registration number and shall be signed by the new responsible individual. No fee shall be required for the modification.

a. Individual practitioners and researchers. Responsibility under a registration issued to an individual practitioner or researcher shall remain with the named individual practitioner or researcher. The responsible individual under such registration may not be changed or transferred.

b. Pharmacy, hospital, care facility, service program, manufacturer, distributor, analytical laboratory, teaching institution, importer, or exporter. The registrant shall submit a completed application and fee for change in registration simultaneously with any other required application pursuant to the board’s rules for the applicable license or registration. In the absence of a simultaneous license or registration application, the registrant shall submit a completed application and fee for change in registration within ten days of the identification of a new responsible individual.

10.9(6) Termination of registration. A registration issued to an individual or business shall terminate when the registered individual or business ceases legal existence, discontinues business, or discontinues professional practice. A registration issued to an individual shall terminate upon the death of the individual.

[ARC 3345C, IAB 9/27/17, effective 11/1/17; ARC 4455C, IAB 5/22/19, effective 6/26/19]

657—10.10(124) Denial of application or discipline of registration.

10.10(1) Grounds for denial or discipline. The board may deny any application or discipline any registration upon a finding that the applicant or registrant:

a. Has furnished false or fraudulent material information.

b. Has had the applicant’s or registrant’s federal registration to manufacture, distribute, or dispense controlled substances suspended, revoked, or otherwise sanctioned.

c. Has been convicted of a public offense under any state or federal law relating to any controlled substance. For the purpose of this rule only, a conviction shall include a plea of guilty, a forfeiture of bail or collateral deposited to secure a defendant’s appearance in court which forfeiture has not been vacated, or a finding of guilt in a criminal action even if entry of the judgment or sentence has been withheld and the applicant or registrant has been placed on probation.

d. Has committed such acts as would render the applicant’s or registrant’s registration under Iowa Code section 124.303 inconsistent with the public interest as determined by that section.

e. Has been subject to discipline by the applicant’s or registrant’s respective professional licensing board and the discipline revokes or suspends the applicant’s or registrant’s professional license or otherwise disciplines the applicant’s or registrant’s professional license in a way that restricts the applicant’s or registrant’s authority to handle or prescribe controlled substances. A copy of the record of licensee discipline or a copy of the licensee’s surrender of the professional license shall be conclusive evidence.

f. Has failed to obtain or maintain active registration while engaged in activities which require registration.

10.10(2) Considerations in denial of application or discipline of registration. In determining the public interest, the board shall consider all the following factors:

a. Maintenance of effective controls against diversion of controlled substances into channels other than legitimate medical, scientific, or industrial channels.

b. Compliance with applicable state and local law.

c. Any convictions of the applicant or registrant under any federal and state laws relating to any controlled substance.

d. Past experience in the manufacture or distribution of controlled substances, and the existence in the applicant’s or registrant’s establishment of effective controls against diversion.
e. Furnishing by the applicant of false or fraudulent material in any application filed under this chapter.

f. Suspension or revocation of the applicant’s or registrant’s federal registration to manufacture, distribute, or dispense controlled substances as authorized by federal law.

g. Any other factors relevant to and consistent with the public health and safety.

h. Failure of a prescribing practitioner, except a licensed veterinarian, to register with the PMP pursuant to subrule 10.5(2).

10.10(3) Proceedings.

a. Prior to denying an application for registration, the board shall serve upon the applicant a notice of intent to deny the application. An applicant has 30 days to appeal a notice of intent to deny the application. If the notice of intent to deny the application is timely appealed, a notice of hearing shall be issued, initiating a contested case proceeding governed by 657—Chapter 35. Proceedings to refuse renewal of a registration shall not abate the existing registration, which shall remain in effect pending the outcome of the contested case proceeding. A registration may be disciplined in accordance with 657—Chapters 35 and 36.

b. Prior to sanctioning a registration, the board shall serve upon the registrant a notice of hearing and statement of charges. The notice shall contain a statement of the basis therefore and shall call upon the registrant to appear before an administrative law judge or the board at a time and place not less than 30 days after the date of service of the notice. The notice shall also contain a statement of the legal basis for such hearing and for the sanction of registration and a summary of the matters of fact and law asserted. Proceedings to refuse renewal of registration shall not abate the existing registration, which shall remain in effect pending the outcome of the administrative hearing unless the board issues an order of immediate suspension. A registration may be disciplined in accordance with 657—Chapters 35 and 36.

10.10(4) Disposition of controlled substances. Upon service of an order of the board suspending or revoking a registration, the registrant shall deliver all affected controlled substances in the registrant’s possession to the board or authorized agent of the board. Upon receiving the affected controlled substances from the registrant, the board or its authorized agent shall place all such substances under seal and retain the sealed controlled substances pending final resolution of any appeals or until a court of competent jurisdiction directs otherwise. No disposition may be made of the substances under seal until the time for filing an appeal has elapsed or until all appeals have been concluded unless a court, upon application, orders the sale of perishable substances and the deposit of proceeds of the sale with the court. Upon a revocation order’s becoming final, all such controlled substances may be forfeited to the state.

[ARC 4455C, IAB 5/22/19, effective 6/26/19]

657—10.11(124,147,155A) Registration verification. The board may require a nonrefundable fee of $15 for completion of a request for written verification of any registration.

[ARC 4455C, IAB 5/22/19, effective 6/26/19]

657—10.12(124) Inspection. The board may inspect, or cause to be inspected, the establishment of an applicant or registrant. The board shall review the application for registration and other information regarding an applicant or registrant in order to determine whether the applicant or registrant has met the applicable standards of Iowa Code chapter 124 and these rules.

[ARC 3345C, IAB 9/27/17, effective 11/1/17]

657—10.13(124) Security requirements. All registrants shall provide effective controls and procedures to guard against theft and diversion of controlled substances. In order to determine whether a registrant has provided effective controls against diversion, the board shall use the security requirements set forth in these rules as standards for the physical security controls and operating procedures necessary to prevent diversion.

10.13(1) Physical security. Physical security controls shall be commensurate with the schedules and quantity of controlled substances in the possession of the registrant in normal business operation. A
registrant shall periodically review and adjust security measures based on rescheduling of substances or changes in the quantity of substances in the possession of the registrant.

a. Controlled substances listed in Schedule I shall be stored in a securely locked, substantially constructed cabinet or safe.

b. Controlled substances listed in Schedules II through V may be stored in a securely locked, substantially constructed cabinet or safe. However, pharmacies and hospitals may disperse these substances throughout the stock of noncontrolled substances in a manner so as to obstruct the theft or diversion of the controlled substances.

c. Controlled substances collected via an authorized collection program for the purpose of disposal shall be stored pursuant to federal regulations, which can be found at www.deadiversion.usdoj.gov/drug_disposal/.

10.13(2) Factors in evaluating physical security systems. In evaluating the overall security system of a registrant or applicant necessary to maintain effective controls against theft or diversion of controlled substances, the board may consider any of the following factors it deems relevant to the need for strict compliance with the requirements of this rule:

a. The type of activity conducted.

b. The type, form, and quantity of controlled substances handled.

c. The location of the premises and the relationship such location bears to security needs.

d. The type of building construction comprising the facility and the general characteristics of the building or buildings.

e. The type of vault, safe, and secure enclosures available.

f. The type of closures on vaults, safes, and secure enclosures.

g. The adequacy of key control systems or combination lock control systems.

h. The adequacy of electronic detection and alarm systems, if any.

i. The adequacy of supervision over employees having access to controlled substances, to storage areas, or to manufacturing areas.

j. The extent of unsupervised public access to the facility, including the presence and characteristics of perimeter fencing, if any.

k. The procedures for handling business guests, visitors, maintenance personnel, and nonemployee service personnel.

l. The availability of local police protection or of the registrant’s or applicant’s security personnel.

m. The adequacy of the registrant’s or applicant’s system for monitoring the receipt, manufacture, distribution, and disposition of controlled substances.

10.13(3) Manufacturing and compounding storage areas. Raw materials, bulk materials awaiting further processing, and finished products which are controlled substances listed in any schedule shall be stored pursuant to federal laws and regulations.

[ARC 3345C, IAB 9/27/17, effective 11/1/17]

657—10.14(124) Accountability of controlled substances. The registrant shall maintain ultimate accountability of controlled substances and records maintained at the registered location.

10.14(1) Records. Pursuant to rule 657—10.36(124,155A), records shall be available for inspection and copying by the board or its authorized agents for two years from the date of the record.

10.14(2) Policies and procedures. The registrant shall have policies and procedures that identify, at a minimum:

a. Adequate storage for all controlled substances to ensure security and proper conditions with respect to temperature and humidity.

b. Access to controlled substances and records of controlled substances by employees of the registrant.

c. Proper disposition of controlled substances.

[ARC 3345C, IAB 9/27/17, effective 11/1/17]

657—10.15 Reserved.
657—10.16(124) Receipt and disbursement of controlled substances. Each transfer of a controlled substance between two registrants, to include a transfer between two separately registered locations regardless of any common ownership, except as provided in subrule 10.16(2), shall require a record of the transaction. Each registrant shall maintain a copy of the record for at least two years from the date of the transfer. Records of the transfer of Schedule II controlled substances shall be created and maintained separately from records of the transfer of Schedules III through V controlled substances pursuant to rule 657—10.36(124,155A). Upon receipt of a controlled substance, the individual responsible for receiving the controlled substance shall date and sign the receipt record.

10.16(1) Record. The record, unless otherwise provided in these rules or pursuant to federal law, shall include the following:

- a. The name of the substance.
- b. The strength and dosage form of the substance.
- c. The number of units or commercial containers acquired from other registrants, including the date of receipt and the name, address, and DEA registration number of the registrant from which the substances were acquired.
- d. The number of units or commercial containers distributed to other registrants, including the date of distribution and the name, address, and DEA registration number of the registrant to which the substances were distributed.
- e. The number of units or commercial containers disposed of in any other manner, including the date and manner of disposal and the name, address, and DEA registration number of the registrant to which the substances were distributed for disposal, if appropriate.

10.16(2) Distribution of samples and other complimentary packages. Complimentary packages and samples of controlled substances may be distributed to practitioners pursuant to federal and state law only if the person distributing the items provides to the practitioner a record that contains the information found in this subrule. The individual responsible for receiving the controlled substances shall sign and date the record.

- a. The name, address, and DEA registration number of the supplier.
- b. The name, address, and DEA registration number of the practitioner.
- c. The name, strength, dosage form, and quantity of the specific controlled substances delivered.
- d. The date of delivery.

[ARC 3345C; IAB 9/27/17, effective 11/1/17]

657—10.17(124) Ordering or distributing Schedule I or II controlled substances.

10.17(1) DEA Form 222. Except as otherwise provided by subrule 10.17(2) and under federal law, a DEA Form 222 is required for each distribution of a Schedule I or II controlled substance. An order form may be executed only on behalf of the registrant named on the order form and only if the registrant’s DEA and Iowa registrations for the substances being purchased have not expired or been revoked or suspended by the issuing agency.

- a. Order forms shall be obtained, executed, and filled pursuant to DEA requirements. Each form shall be complete, legible, and properly prepared, executed, and endorsed and shall contain no alteration, erasure, or change of any kind.
- b. The purchaser shall submit Copy 1 and Copy 2 of the order form to the supplier.
- c. The purchaser shall maintain Copy 3 of the order form in the files of the registrant. Upon receipt of the substances from the supplier, the purchaser shall record on Copy 3 of the order form the quantity of each substance received and the date of receipt.
- d. The supplier shall record on Copy 1 and Copy 2 of the order form the quantity of each substance distributed to the purchaser and the date on which the shipment is made. The supplier shall maintain Copy 1 of the order form in the files of the supplier and shall forward Copy 2 of the order form to the DEA district office.
- e. Order forms shall be maintained separately from all other records of the registrant.
- f. Each unaccepted, defective, or otherwise void order form and any attached statement or other documents relating to any order form shall be maintained in the files of the registrant.
g. If the registration of any purchaser of Schedule I or II controlled substances is terminated for any reason, or if the name or address of the registrant as shown on the registration is changed, the registrant shall return all unused order forms to the DEA district office.

10.17(2) Electronic ordering system. A registrant authorized to order or distribute Schedule I or II controlled substances via the DEA Controlled Substances Ordering System (CSOS) shall comply with the requirements of the DEA relating to that system, including the maintenance and security of digital certificates, signatures, and passwords and all record-keeping and reporting requirements.

a. For an electronic order to be valid, the purchaser shall sign the electronic order with a digital signature issued to the purchaser or the purchaser’s agent by the DEA.

b. An electronic order may include controlled substances that are not in Schedule I or II and may also include noncontrolled substances.

c. A purchaser shall submit an order to a specific wholesale distributor appropriately licensed to distribute in Iowa.

d. Prior to filling an order, a supplier shall verify the integrity of the signature and the order, verify that the digital certificate has not expired, check the validity of the certificate, and verify the registrant’s authority to order the controlled substances.

e. The supplier shall retain an electronic record of every order, including a record of the number of commercial or bulk containers furnished for each item and the date on which the supplier shipped the containers to the purchaser. The shipping record shall be linked to the electronic record of the order. Unless otherwise provided under federal law, a supplier shall ship the controlled substances to the registered location associated with the digital certificate used to sign the order.

f. If an order cannot be filled for any reason, the supplier shall notify the purchaser and provide a statement as to the reason the order cannot be filled. When a purchaser receives such a statement from a supplier, the purchaser shall electronically link the statement of nonacceptance to the original electronic order. Neither a purchaser nor a supplier may correct a defective order; the purchaser must issue a new order for the order to be filled.

g. When a purchaser receives a shipment, the purchaser shall create a record of the quantity of each item received and the date received. The record shall be electronically linked to the original order and shall identify the individual reconciling the order. A purchaser shall, for each order filled, retain the original signed order and all linked records for that order for two years. The purchaser shall also retain all copies of each unfilled or defective order and each linked statement.

h. A supplier shall retain each original order filled and all linked records for two years. A supplier shall, for each electronic order filled, forward to the DEA within two business days either a copy of the electronic order or an electronic report of the order in a format specified by the DEA.

i. Records of CSOS electronic orders and all linked records shall be maintained by a supplier and a purchaser for two years following the date of shipment or receipt, respectively. Records may be maintained electronically or in hard-copy format. Records that are maintained electronically shall be readily retrievable from all other records, shall be easily readable or easily rendered into a readable format, shall be readily retrievable at the registered location, and shall be made available to the board, to the board’s agents, or to the DEA upon request. Records maintained in hard-copy format shall be maintained in the same manner as DEA Form 222.

[ARC 3345C, IAB 9/27/17, effective 11/1/17]

657—10.18(124) Schedule II perpetual inventory. Each registrant located in Iowa that maintains Schedule II controlled substances shall maintain a perpetual inventory system for all Schedule II controlled substances pursuant to this rule. All records relating to the perpetual inventory shall be maintained at the registered location and shall be available for inspection and copying by the board or its representative for a period of two years from the date of the record.

10.18(1) Record format. The perpetual inventory record may be maintained in a manual or an electronic record format. Any electronic record shall provide for hard-copy printout of all transactions recorded in the perpetual inventory record for any specified period of time and shall state the current inventory quantities of each drug at the time the record is printed.
10.18(2) *Information included.* The perpetual inventory record shall identify all receipts for and disbursements of Schedule II controlled substances by drug or by national drug code (NDC) number. The record shall be updated to identify each receipt, disbursement, and current balance of each individual drug or NDC number. The record shall also include incident reports and reconciliation records pursuant to subrules 10.18(3) and 10.18(4).

10.18(3) *Changes to a record.* If a perpetual inventory record is able to be changed, the individual making a change to the record shall complete an incident report documenting the change. The incident report shall identify the specific information that was changed including the information before and after the change, shall identify the individual making the change, and shall include the date and the reason the record was changed. If the electronic record system documents within the perpetual inventory record all of the information that must be included in an incident report, a separate report is not required.

10.18(4) *Reconciliation.* The registrant shall be responsible for reconciling or ensuring the completion of a reconciliation of the perpetual inventory balance with the physical inventory of all Schedule II controlled substances at least annually. In case of any discrepancies between the physical inventory and the perpetual inventory, the registrant shall be notified immediately. The registrant shall determine the need for further investigation, and significant discrepancies shall be reported to the board pursuant to rule 657—10.21(124) and to the DEA pursuant to federal DEA regulations. Periodic reconciliation records shall be maintained and available for review and copying by the board or its authorized agents for a period of two years from the date of the record. The reconciliation process may be completed using either of the following procedures or a combination thereof:

a. The individual responsible for a disbursement verifies that the physical inventory matches the perpetual inventory following each disbursement and documents that reconciliation in the perpetual inventory record. If controlled substances are maintained on the patient care unit, the nurse or other responsible licensed health care provider verifies that the physical inventory matches the perpetual inventory following each dispensing and documents that reconciliation in the perpetual inventory record. If any Schedule II controlled substances in the registrant’s current inventory have been disbursed and verified in this manner within the year and there are no discrepancies noted, no additional reconciliation action is required. A perpetual inventory record for a drug that has had no activity within the year shall be reconciled pursuant to paragraph 10.18(4) “b.”

b. A physical count of each Schedule II controlled substance stocked by the registrant shall be completed at least once each year, and that count shall be reconciled with the perpetual inventory record balance. The physical count and reconciliation may be completed over a period of time not to exceed one year in a manner that ensures that the perpetual inventory and the physical inventory of Schedule II controlled substances are annually reconciled. The individual performing the reconciliation shall record the date, the time, the individual’s initials or unique identification, and any discrepancies between the physical inventory and the perpetual inventory.

[ARC 3345C; IAB 9/27/17, effective 11/1/17]

657—10.19(124) *Physical count and record of inventory.* Each registrant shall be responsible for taking a complete and accurate inventory of all stocks of controlled substances under the control of the registrant pursuant to this rule. The responsible individual may delegate the actual taking of any inventory.

10.19(1) *Record and procedure.* Each inventory record, except the periodic count and reconciliation required pursuant to subrule 10.18(4), shall comply with the requirements of this subrule and shall be maintained for a minimum of two years from the date of the inventory.

a. Each inventory shall contain a complete and accurate record of all controlled substances on hand on the date and at the time the inventory is taken.

b. Each inventory shall be maintained in a handwritten, typewritten, or electronically printed form at the registered location. An inventory of Schedule II controlled substances shall be maintained separately from an inventory of all other controlled substances.

c. Controlled substances shall be deemed to be on hand if they are in the possession of or under the control of the registrant. Controlled substances on hand shall include prescriptions prepared for
dispensing to a patient but not yet delivered to the patient, substances maintained in emergency medical service programs, care facility or hospice emergency supplies, outdated or adulterated substances pending destruction, and substances stored in a warehouse on behalf of the registrant. Controlled substances obtained through an authorized collection program for the purpose of disposal shall not be examined, inspected, counted, sorted, inventoried, or otherwise handled.

d. A separate inventory shall be made for each registered location and for each independent activity registered except as otherwise provided under federal law.

e. The inventory shall be taken either prior to opening or following the close of business on the inventory date, and the inventory record shall identify either opening or close of business.

f. The inventory record, unless otherwise provided under federal law, shall include the following information:

   (1) The name of the substance.

   (2) The strength and dosage form of the substance.

   (3) The quantity of the substance.

   (4) Information required of authorized collection programs pursuant to federal regulations for such collection programs.

   (5) The signature of the person or persons responsible for taking the inventory.

   (6) The date and time (opening or closing) of the inventory.

   g. For all substances listed in Schedule I or II, the quantity shall be an exact count or measure of the substance.

   h. For all substances listed in Schedule III, IV, or V, the quantity may be an estimated count or measure of the substance unless the container has been opened and originally held more than 100 dosage units. If the opened commercial container originally held more than 100 dosage units, an exact count of the contents shall be made. Products packaged in nonincremented containers may be estimated to the nearest one-fourth container.

10.19(2) Initial inventory. A new registrant shall take an inventory of all stocks of controlled substances on hand on the date the new registrant first engages in the manufacture, distribution, storage, or dispensing of controlled substances. If the registrant commences business or the registered activity with no controlled substances on hand, the initial inventory shall record that fact.

10.19(3) Annual inventory. After the initial inventory is taken, a registrant shall take a new inventory of all stocks of controlled substances on hand at least annually. The annual inventory may be taken on any date that is within 372 days after the date of the previous annual inventory.

10.19(4) Change of ownership, pharmacist in charge, or registered location. When there is a change in ownership, pharmacist in charge, or location for a registration, an inventory shall be taken of all controlled substances in compliance with subrule 10.19(1). The inventory shall be taken following the close of business the last day under terminating ownership, terminating pharmacist in charge’s employment, or at the location being vacated. The inventory shall serve as the ending inventory for the terminating owner, terminating pharmacist in charge, or location being vacated, as well as a record of the beginning inventory for the new owner, pharmacist in charge, or location.

10.19(5) Discontinuing registered activity. A registrant shall take an inventory of controlled substances at the close of business the last day the registrant is engaged in registered activities. If the registrant is selling or transferring the remaining controlled substances to another registrant, this inventory shall serve as the ending inventory for the registrant discontinuing business as well as a record of additional or starting inventory for the registrant to which the substances are transferred.

10.19(6) New or rescheduled controlled substances. On the effective date of the addition of a previously noncontrolled substance to any schedule of controlled substances or the rescheduling of a previously controlled substance to another schedule, any registrant who possesses the newly scheduled or rescheduled controlled substance shall take an inventory of all stocks of the substance on hand. That inventory record shall be maintained with the most recent controlled substances inventory record. Thereafter, the controlled substance shall be included in the appropriate schedule of each inventory made by the registrant.

[ARC 3345C, IAB 9/27/17, effective 11/1/17]
657—10.20 Reserved.

657—10.21(124) Report of theft or loss. A registrant shall report to the board and the DEA any theft or significant loss of controlled substances when the loss is attributable to other than inadvertent error. Thefts or other losses of controlled substances shall be reported whether or not the controlled substances are subsequently recovered or the responsible parties are identified and action taken against them.

10.21(1) Immediate notice to board. If the theft was committed by a registrant or licensee of the board, or if there is reason to believe that the theft was committed by a registrant or licensee of the board, the registrant from which the controlled substances were stolen shall notify the board immediately upon discovery of the theft and shall identify to the board the registrant or licensee suspected of the theft.

10.21(2) Immediate notice to DEA. A registrant shall deliver notice, immediately upon discovery of a reportable theft or loss of controlled substances, to the Des Moines DEA field office via telephone, facsimile, or a brief written message explaining the circumstances of the theft or loss.

10.21(3) Timely report submission. Within 14 calendar days of discovery of the theft or loss, a registrant shall submit directly to the DEA a Form 106 or alternate required form via the DEA website at www.deadiversion.usdoj.gov/. A copy of the report that was completed and submitted to the DEA shall be immediately submitted to the board via facsimile, email attachment, or personal or commercial delivery.

10.21(4) Record maintained. A copy of the report shall be maintained in the registrant’s files for a minimum of two years following the date the report was completed.

[ARC 3345C, IAB 9/27/17, effective 11/1/17]

657—10.22(124) Disposal of registrant stock. A registrant shall dispose of controlled substances pursuant to the requirements of this rule. Disposal records shall be maintained by the registrant for at least two years from the date of the record.

10.22(1) Registrant stock supply. Controlled substances shall be removed from current inventory and disposed of by one of the following procedures.

a. The registrant shall utilize the services of a DEA-registered and Iowa-licensed reverse distributor.

b. The board may authorize and instruct the registrant to dispose of the controlled substances in one of the following manners:

(1) By delivery to an agent of the board or to the board office.

(2) By destruction of the drugs in the presence of a board officer, agent, inspector, or other authorized individual.

(3) By such other means as the board may determine to ensure that drugs do not become available to unauthorized persons.

10.22(2) Waste resulting from administration or compounding. Except as otherwise specifically provided by federal or state law or rules of the board, the unused portion of a controlled substance resulting from administration to a patient from a registrant’s stock or emergency supply or resulting from drug compounding operations may be destroyed or otherwise disposed of by the registrant, a certified paramedic, or a pharmacist in witness of one other licensed health care provider or a registered pharmacy technician 18 years of age or older pursuant to this subrule. A written record of the wastage shall be made and maintained by the registrant for a minimum of two years following the wastage. The record shall include the following:

a. The controlled substance wasted.

b. The date of wastage.

c. The quantity or estimated quantity of the wasted controlled substance.

d. The source of the controlled substance, including identification of the patient to whom the substance was administered or the drug compounding process utilizing the controlled substance.

e. The reason for the waste.

f. The signatures of both individuals involved in the wastage.

[ARC 3345C, IAB 9/27/17, effective 11/1/17; ARC 4455C, IAB 5/22/19, effective 6/26/19]
657—10.23(124) Disposal of previously dispensed controlled substances.

10.23(1) Registrant disposal. Except as provided in 657—Chapter 23 for care facilities, a registrant may not dispose of previously dispensed controlled substances unless the registrant has modified its registration with DEA to administer an authorized collection program. A registrant shall not take possession of a previously dispensed controlled substance except for reuse for the same patient or except as provided in paragraph 10.23(2) "b."

10.23(2) Hospice disposal.

a. An employee of a hospice program, acting within the scope of employment, may dispose of a controlled substance of a hospice program patient following the death of the patient or the expiration of the controlled substance pursuant to and in compliance with federal law.

b. A physician of a hospice program patient may dispose of a patient’s controlled substance which is no longer required due to a change in the patient’s care plan.

[ARC 3345C, IAB 9/27/17; effective 11/1/17; ARC 4455C, IAB 5/22/19, effective 6/26/19]

657—10.24(124,126,155A) Prescription requirements. All prescriptions for controlled substances shall be dated as of, and signed on, the day issued. Controlled substances prescriptions shall be valid for six months following date of issue. A prescription for a Schedule III, IV, or V controlled substance may include authorization to refill the prescription no more than five times within the six months following date of issue. A prescription for a Schedule II controlled substance shall not be refilled. Beginning January 1, 2020, all prescriptions for controlled substances shall be transmitted electronically to a pharmacy pursuant to rule 657—21.6(124,155A), except as provided in rule 657—21.8(124,155A).

10.24(1) Form of prescription. All prescriptions for controlled substances shall bear the full name and address of the patient; the drug name, strength, dosage form, quantity prescribed, and directions for use; and the name, address, and DEA registration number of the prescriber. All prescriptions for controlled substances issued by individual prescribers shall include the legibly preprinted, typed, or hand-printed name of the prescriber as well as the prescriber’s written or electronic signature. A prescription for a controlled substance issued prior to January 1, 2020, or a prescription for a controlled substance that is exempt from the electronic prescription mandate pursuant to rule 657—21.8(124,155A), may be transmitted via nonelectronic methods as described in this rule.

a. When an oral order is not permitted, or when a prescriber is unable to prepare and transmit an electronic prescription in compliance with DEA requirements for electronic prescriptions, prescriptions shall be written with ink, indelible pencil, or typed print and shall be manually signed by the prescriber. If the prescriber utilizes an electronic prescription application that meets DEA requirements for electronic prescriptions, the prescriber may electronically prepare and transmit a prescription for a controlled substance to a pharmacy that utilizes a pharmacy prescription application that meets DEA requirements for electronic prescriptions.

b. A prescriber’s agent may prepare a prescription for the review, authorization, and manual or electronic signature of the prescriber, but the prescribing practitioner is responsible for the accuracy, completeness, and validity of the prescription.

c. An electronic prescription for a controlled substance shall not be transmitted to a pharmacy except by the prescriber in compliance with DEA regulations.

d. A prescriber shall securely maintain the unique authentication credentials issued to the prescriber for utilization of the electronic prescription application and authentication of the prescriber’s electronic signature. Unique authentication credentials issued to any individual shall not be shared with or disclosed to any other prescriber, agent, or individual.

e. A corresponding liability rests upon the pharmacist who fills a prescription not prepared in the form prescribed by this rule.

10.24(2) Verification by pharmacist.

a. The pharmacist shall verify the authenticity of the prescription with the individual prescriber or the prescriber’s agent in each case when a written or oral prescription for a Schedule II controlled substance is presented for filling and neither the prescribing individual practitioner issuing the prescription nor the patient or patient’s agent is known to the pharmacist. The pharmacist shall verify
the authenticity of the prescription with the individual prescriber or the prescriber’s agent in any case when the pharmacist questions the validity of, including the legitimate medical purpose for, the prescription. The pharmacist is required to record the manner by which the prescription was verified and include the pharmacist’s name or unique identifier.

b. A pharmacist who receives a written, oral, or facsimile prescription shall not be required to verify that the prescription is subject to an exception to the electronic prescription mandate provided in rule 657—21.8(124,155A) and may dispense a prescription drug pursuant to an otherwise valid written, oral, or facsimile prescription pursuant to this rule.

10.24(3) Intern, resident, foreign physician. An intern, resident, or foreign physician exempt from registration pursuant to subrule 10.8(5) shall include on all prescriptions issued the hospital’s registration number and the special internal code number assigned by the hospital in lieu of the prescriber’s registration number required by this rule. Each prescription shall include the stamped or legibly printed name of the prescribing intern, resident, or foreign physician as well as the prescriber’s signature.

10.24(4) Valid prescriber/patient relationship. Once the prescriber/patient relationship is broken and the prescriber is no longer available to treat the patient or to oversee the patient’s use of the controlled substance, a prescription shall lose its validity. A prescriber/patient relationship shall be deemed broken when the prescriber dies, retires, or moves out of the local service area or when the prescriber’s authority to prescribe is suspended, revoked, or otherwise modified to exclude authority for the schedule in which the prescribed substance is listed. The pharmacist, upon becoming aware of the situation, shall cancel the prescription and any remaining refills. However, the pharmacist shall exercise prudent judgment based upon individual circumstances to ensure that the patient is able to obtain a sufficient amount of the drug to continue treatment until the patient can reasonably obtain the service of another prescriber and a new prescription can be issued.

10.24(5) Facsimile transmission of a controlled substance prescription. With the exception of an authorization for emergency dispensing as provided in rule 657—10.26(124), a prescription for a controlled substance in Schedules II, III, IV and V may be transmitted via facsimile from a prescriber to a pharmacy only as provided in rule 657—21.7(124,155A).

[ARC 3345C, IAB 9/27/17, effective 1/1/17; ARC 4580C, IAB 7/31/19, effective 9/4/19]

657—10.25(124) Dispensing records. Each registrant shall create a record of controlled substances dispensed to a patient or research subject.

10.25(1) Record maintained and available. The record shall be maintained for two years from the date of dispensing and be available for inspection and copying by the board or its authorized agents.

10.25(2) Record contents. The record shall include the following information:

a. The name and address of the person to whom dispensed.

b. The date of dispensing.

c. The name or NDC number, strength, dosage form, and quantity of the substance dispensed.

d. The name of the prescriber, unless dispensed by the prescriber.

e. The unique identification of each technician, pharmacist, pharmacist-intern, prescriber, or prescriber’s agent involved in dispensing.

f. The serial number or unique identification number of the prescription.

[ARC 3345C, IAB 9/27/17, effective 1/1/17]

657—10.26(124) Schedule II emergency prescriptions.

10.26(1) Emergency situation defined. For the purposes of authorizing an oral or facsimile transmission of a prescription for a Schedule II controlled substance listed in Iowa Code section 124.206, the term “emergency situation” means those situations in which the prescribing practitioner determines that all of the following apply:

a. Immediate administration of the controlled substance is necessary for proper treatment of the intended ultimate user.

b. No appropriate alternative treatment is available, including administration of a drug that is not a Schedule II controlled substance.
c. It is not reasonably possible for the prescribing practitioner to provide a manually signed written prescription to be presented to the pharmacy before the pharmacy dispenses the controlled substance, or the prescribing practitioner is unable to provide a DEA-compliant electronic prescription to the pharmacy before the pharmacy dispenses the controlled substance.

10.26(2) Requirements of emergency prescription. In the case of an emergency situation as defined in subrule 10.26(1), a pharmacist may dispense a controlled substance listed in Schedule II pursuant to a facsimile transmission or upon receiving oral authorization of a prescribing individual practitioner provided that:

a. The quantity prescribed and dispensed is limited to the smallest available quantity to meet the needs of the patient during the emergency period. Dispensing beyond the emergency period requires a written prescription manually signed by the prescribing individual practitioner or a DEA-compliant electronic prescription.

b. If the pharmacist does not know the prescribing individual practitioner, the pharmacist shall make a reasonable effort to determine that the authorization came from an authorized prescriber. The pharmacist shall record the manner by which the authorization was verified and include the pharmacist’s name or unique identification.

c. The pharmacist shall prepare a temporary written record of the emergency prescription. The temporary written record shall consist of a hard copy of the facsimile transmission or a written record of the oral transmission authorizing the emergency dispensing. A written record is not required to consist of a handwritten record and may be a printed facsimile or a print of a computer-generated record of the prescription if the printed record includes all of the required elements for the prescription. If the emergency prescription is transmitted by the practitioner’s agent, the record shall include the first and last names and title of the individual who transmitted the prescription.

d. If the emergency prescription is transmitted via facsimile transmission, the means of transmission shall not obscure or render the prescription information illegible due to security features of the paper utilized by the prescriber to prepare the written prescription, and the hard-copy record of the facsimile transmission shall not be obscured or rendered illegible due to such security features.

e. Within seven days after authorizing an emergency prescription, the prescribing individual practitioner shall cause a written prescription for the emergency quantity prescribed to be delivered to the dispensing pharmacist. In addition to conforming to the requirements of rule 657—10.24(124,126,155A), the prescription shall have written on its face “Authorization for Emergency Dispensing” and the date of the emergency order. The written prescription may be delivered to the pharmacist in person or by mail, but if delivered by mail it must be postmarked within the seven-day period. The written prescription shall be attached to and maintained with the temporary written record prepared pursuant to paragraph 10.26(2)”c.”

f. The pharmacist shall notify the board and the DEA if the prescribing individual fails to deliver a written prescription. Failure of the pharmacist to so notify the board and the DEA, or failure of the prescribing individual to deliver the required written prescription as herein required, shall void the authority conferred by this subrule.

g. Pursuant to federal law and subrule 10.27(3), the pharmacist may fill a partial quantity of an emergency prescription so long as the total quantity dispensed in all partial fillings does not exceed the total quantity prescribed and that the remaining portions are filled no later than 72 hours after the prescription is issued.

[ARC 3345C, IAB 9/27/17, effective 11/1/17]

657—10.27(124) Schedule II prescriptions—partial filling. The partial filling of a prescription for a controlled substance listed in Schedule II is permitted as provided in this rule and federal regulations.

10.27(1) Insufficient supply on hand. If the pharmacist is unable to supply the full quantity authorized in a prescription and makes a notation of the quantity supplied on the prescription record, a partial fill of the prescription is permitted. The remaining portion of the prescription must be filled within 72 hours of the first partial filling. If the remaining portion is not or cannot be filled within
the 72-hour period, the pharmacist shall so notify the prescriber. No further quantity may be supplied beyond 72 hours without a new prescription.

10.27(2) Long-term care or terminally ill patient. A prescription for a Schedule II controlled substance written for a patient in a long-term care facility (LTCF) or for a patient with a medical diagnosis documenting a terminal illness may be filled in partial quantities to include individual dosage units as provided by this subrule.

a. If there is any question whether a patient may be classified as having a terminal illness, the pharmacist shall contact the practitioner prior to partially filling the prescription. Both the pharmacist and the practitioner have a corresponding responsibility to ensure that the controlled substance is for a terminally ill patient.

b. The pharmacist shall record on the prescription whether the patient is “terminally ill” or an “LTCF patient.” For each partial filling, the dispensing pharmacist shall record on the back of the prescription or on another appropriate uniformly maintained and readily retrievable record, the date of the partial filling, the quantity dispensed, the remaining quantity authorized to be dispensed, and the identification of the dispensing pharmacist.

c. The total quantity of Schedule II controlled substances dispensed in all partial fillings shall not exceed the total quantity prescribed. Schedule II prescriptions for patients in an LTCF or for patients with a medical diagnosis documenting a terminal illness shall be valid for a period not to exceed 60 days from the issue date unless sooner terminated by the discontinuance of the drug.

d. Information pertaining to current Schedule II prescriptions for patients in an LTCF or for patients with a medical diagnosis documenting a terminal illness may be maintained in a computerized system pursuant to rule 657—21.5(124,155A).

10.27(3) Patient or prescriber request. At the request of the patient or prescriber, a prescription for a Schedule II controlled substance may be partially filled pursuant to this subrule and federal law. The total quantity dispensed in all partial fillings shall not exceed the total quantity prescribed. Except as provided in paragraph 10.26(2) “g,” the remaining portion of a prescription partially filled pursuant to this subrule may be filled within 30 days of the date the prescription was issued.

[ARC 3345C, IAB 9/27/17, effective 11/1/17; ARC 4455C, IAB 5/22/19, effective 6/26/19]

657—10.28(124) Schedule II medication order. Schedule II controlled substances may be administered or dispensed to institutionalized patients pursuant to a medication order as provided in 657—subrule 7.13(1) or rule 657—23.9(124,155A), as applicable.

[ARC 3345C, IAB 9/27/17, effective 11/1/17; ARC 3855C, IAB 6/20/18, effective 7/25/18]

657—10.29(124) Schedule II—issuing multiple prescriptions. An individual prescriber may issue multiple prescriptions authorizing the patient to receive a total of up to a 90-day supply of a Schedule II controlled substance pursuant to the provisions and limitations of this rule.

10.29(1) Refills prohibited. The issuance of refills for a Schedule II controlled substance is prohibited. The use of multiple prescriptions for the dispensing of Schedule II controlled substances, pursuant to this rule, ensures that the prescriptions are treated as separate dispensing authorizations and not as refills of an original prescription.

10.29(2) Legitimate medical purpose. Each separate prescription issued pursuant to this rule shall be issued for a legitimate medical purpose by an individual prescriber acting in the usual course of the prescriber’s professional practice.

10.29(3) Dates and instructions. Each prescription issued pursuant to this rule shall be dated as of and manually or electronically signed by the prescriber on the day the prescription is issued. Each separate prescription, other than the first prescription if that prescription is intended to be filled immediately, shall contain written instructions indicating the earliest date on which a pharmacist may fill each prescription.

10.29(4) Authorized fill date unalterable. Regardless of the provisions of rule 657—10.30(124), when a prescription contains instructions from the prescriber indicating that the prescription shall not be filled before a certain date, a pharmacist shall not fill the prescription before that date. The pharmacist
shall not contact the prescriber for verbal authorization to fill the prescription before the fill date originally indicated by the prescriber pursuant to this rule.

10.29(5) Number of prescriptions and authorized quantity. An individual prescriber may issue for a patient as many separate prescriptions, to be filled sequentially pursuant to this rule, as the prescriber deems necessary to provide the patient with adequate medical care. The cumulative effect of the filling of each of these separate prescriptions shall result in the receipt by the patient of a quantity of the Schedule II controlled substance not exceeding a 90-day supply.

10.29(6) Prescriber’s discretion. Nothing in this rule shall be construed as requiring or encouraging an individual prescriber to issue multiple prescriptions pursuant to this rule or to see the prescriber’s patients once every 90 days when prescribing Schedule II controlled substances. An individual prescriber shall determine, based on sound medical judgment and in accordance with established medical standards, how often to see patients and whether it is appropriate to issue multiple prescriptions pursuant to this rule.

657—10.30(124) Schedule II—changes to a prescription. With appropriate verification, a pharmacist may add information provided by the patient or patient’s agent, such as the patient’s address, to a Schedule II controlled substance prescription.

10.30(1) Changes prohibited. A pharmacist shall never change the patient’s name, the controlled substance prescribed except for generic substitution, or the name or signature of the prescriber.

10.30(2) Changes authorized. After consultation with the prescriber or the prescriber’s agent and documentation of such consultation, a pharmacist may change or add the following information on a Schedule II controlled substance prescription:

a. The drug strength.
b. The dosage form.
c. The drug quantity.
d. The directions for use.
e. The date the prescription was issued.
f. The prescriber’s address or DEA registration number.
g. The name of the supervising prescriber if the prescription was issued by a physician assistant.

657—10.31 Reserved.

657—10.32(124) Schedule III, IV, or V prescription. No prescription for a controlled substance listed in Schedule III, IV, or V shall be filled or refilled more than six months after the date on which it was issued nor be refilled more than five times. Beginning January 1, 2020, all prescriptions for controlled substances shall be transmitted electronically to a pharmacy pursuant to rule 657—21.6(124,155A), except as provided in rule 657—21.8(124,155A).

10.32(1) Record. Each filling and refilling of a prescription shall be entered in a uniformly maintained and readily retrievable record in accordance with rule 657—10.25(124). If the pharmacist merely initials or affixes the pharmacist’s unique identifier and dates the back of the prescription, it shall be deemed that the full face amount of the prescription has been dispensed.

10.32(2) Oral refill authorization. The prescribing practitioner may authorize additional refills of Schedule III, IV, or V controlled substances on the original prescription through an oral refill authorization transmitted to an authorized individual at the pharmacy provided the following conditions are met:

a. The total quantity authorized, including the amount of the original prescription, does not exceed five refills nor extend beyond six months from the date of issuance of the original prescription.
b. The pharmacist, pharmacist-intern, or technician who obtains the oral authorization from the prescriber who issued the original prescription documents, on or with the original prescription, the date authorized, the quantity of each refill, the number of additional refills authorized, and the unique identification of the authorized individual.
c. The quantity of each additional refill is equal to or less than the quantity authorized for the initial filling of the original prescription.

d. The prescribing practitioner must execute a new and separate prescription for any additional quantities beyond the five-refill, six-month limitation.

10.32(3) Partial fills. The partial filling of a prescription for a controlled substance listed in Schedule III, IV, or V is permissible provided that each partial fill is recorded in the same manner as a refill pursuant to subrule 10.32(1). The total quantity dispensed in all partial fills shall not exceed the total quantity prescribed.

10.32(4) Medication order: A Schedule III, IV, or V controlled substance may be administered or dispensed to institutionalized patients pursuant to a medication order as provided in 657—subrule 7.13(1) or rule 657—23.9(124.155A), as applicable.

[ARC 3345C, IAB 9/27/17, effective 11/1/17; ARC 4580C, IAB 7/31/19, effective 9/4/19]

657—10.33(124,155A) Dispensing Schedule V controlled substances without a prescription. A controlled substance listed in Schedule V, which substance is not a prescription drug as determined under the federal Food, Drug, and Cosmetic Act, and excepting products containing ephedrine, pseudoephedrine, or phenylpropanolamine, may be dispensed or administered without a prescription by a pharmacist to a purchaser at retail pursuant to the conditions of this rule.

10.33(1) Who may dispense. Dispensing shall be by a licensed Iowa pharmacist or by a registered pharmacist-intern under the direct supervision of a pharmacist preceptor. This subrule does not prohibit, after the pharmacist has fulfilled the professional and legal responsibilities set forth in this rule and has authorized the dispensing of the substance, the completion of the actual cash or credit transaction or the delivery of the substance by a nonpharmacist.

10.33(2) Frequency and quantity. Dispensing at retail to the same purchaser in any 48-hour period shall be limited to no more than one of the following quantities of a Schedule V controlled substance:

a. 240 cc (8 ounces) of any controlled substance containing opium.

b. 120 cc (4 ounces) of any other controlled substance.

c. 48 dosage units of any controlled substance containing opium.

d. 24 dosage units of any other controlled substance.

10.33(3) Age of purchaser. The purchaser shall be at least 18 years of age.

10.33(4) Identification. The pharmacist shall require every purchaser under this rule who is not known by the pharmacist to present a government-issued photo identification, including proof of age when appropriate.

10.33(5) Record. A bound record book (i.e., with pages sewn or glued to the spine) for dispensing of Schedule V controlled substances pursuant to this rule shall be maintained by the pharmacist. The book shall contain the name and address of each purchaser, the name and quantity of controlled substance purchased, the date of each purchase, and the name or unique identification of the pharmacist or pharmacist-intern who approved the dispensing of the substance to the purchaser.

10.33(6) Prescription not required under other laws. No other federal or state law or regulation requires a prescription prior to distributing or dispensing the Schedule V controlled substance.

[ARC 3345C, IAB 9/27/17, effective 11/1/17]

657—10.34(124) Dispensing products containing ephedrine, pseudoephedrine, or phenylpropanolamine without a prescription. A product containing ephedrine, pseudoephedrine, or phenylpropanolamine, which substance is a Schedule V controlled substance and is not listed in another controlled substance schedule, may be dispensed or administered without a prescription by a pharmacist, pharmacist-intern, or certified pharmacy technician to a purchaser at retail pursuant to the conditions of this rule.

10.34(1) Who may dispense. Dispensing shall be by a licensed Iowa pharmacist, by a registered pharmacist-intern under the direct supervision of a pharmacist preceptor, or by a registered certified pharmacy technician under the direct supervision of a pharmacist, except as authorized in 657—Chapter 100. This subrule does not prohibit, after the pharmacist, pharmacist-intern, or certified pharmacy technician has fulfilled the professional and legal responsibilities set forth in this rule and has authorized
the dispensing of the substance, the completion of the actual cash or credit transaction or the delivery of the substance by another pharmacy employee.

10.34(2) Packaging of nonliquid forms. A nonliquid form of a product containing ephedrine, pseudoephedrine, or phenylpropanolamine includes gel caps. Nonliquid forms of these products to be sold pursuant to this rule shall be packaged either in blister packaging with each blister containing no more than two dosage units or, if blister packs are technically infeasible, in unit dose packets or pouches.

10.34(3) Frequency and quantity. Dispensing without a prescription to the same purchaser within any 30-day period shall be limited to products collectively containing no more than 7,500 mg of ephedrine, pseudoephedrine, or phenylpropanolamine; dispensing without a prescription to the same purchaser within a single calendar day shall not exceed 3,600 mg.

10.34(4) Age of purchaser. The purchaser shall be at least 18 years of age.

10.34(5) Identification. The pharmacist, pharmacist-intern, or certified pharmacy technician shall require every purchaser under this rule to present a current government-issued photo identification, including proof of age when appropriate. The pharmacist, pharmacist-intern, or certified pharmacy technician shall be responsible for verifying that the name on the identification matches the name provided by the purchaser and that the photo image depicts the purchaser.

10.34(6) Record. Purchase records shall be recorded in the real-time electronic pseudoephedrine tracking system (PTS) established and administered by the governor’s office of drug control policy pursuant to 657—Chapter 100. If the PTS is unavailable for use, the purchase record shall be recorded in an alternate format and submitted to the PTS as provided in 657—subrule 100.3(4).

a. Alternate record contents. The alternate record shall contain the following:
   (1) The name, address, and signature of the purchaser.
   (2) The name and quantity of the product purchased, including the total milligrams of ephedrine, pseudoephedrine, or phenylpropanolamine contained in the product.
   (3) The date and time of the purchase.
   (4) The name or unique identification of the pharmacist, pharmacist-intern, or certified pharmacy technician who approved the dispensing of the product.

b. Alternate record format. The record shall be maintained using one of the following options:
   (1) A hard-copy record.
   (2) A record in the pharmacy’s electronic prescription dispensing record-keeping system that is capable of producing a hard-copy printout of a record.
   (3) A record in an electronic data collection system that captures each of the data elements required by this subrule and that is capable of producing a hard-copy printout of a record.

c. PTS records retrieval. Pursuant to 657—subrule 100.4(6), the pharmacy shall be able to produce a hard-copy printout of transactions recorded in the PTS by the pharmacy for one or more specific products for a specified period of time upon request by the board or its representative or to such other persons or governmental agencies authorized by law to receive such information.

10.34(7) Notice required. The pharmacy shall ensure that the following notice is provided to purchasers of ephedrine, pseudoephedrine, or phenylpropanolamine products and that the notice is displayed with or on the electronic signature device or is displayed in the dispensing area and visible to the public:

“Warning: Section 1001 of Title 18, United States Code, states that whoever, with respect to the logbook, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any materially false, fictitious, or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, shall be fined not more than $250,000 if an individual or $500,000 if an organization, imprisoned not more than five years, or both.”

[ARC 3345C, IAB 9/27/17, effective 11/1/17]

657—10.35 Reserved.
657—10.36(124,155A) Records. Every record required to be kept under this chapter or under Iowa Code chapter 124 shall be kept by the registrant and be available for inspection and copying by the board or its representative for at least two years from the date of such record except as otherwise required in these rules. Controlled substances records shall be maintained in a readily retrievable manner that establishes the receipt and distribution of all controlled substances. Original records more than 12 months old may be maintained in a secure remote storage area unless such remote storage is prohibited under federal law. If the secure storage area is not located within the same physical structure as the registrant, the records must be retrievable within 48 hours of a request by the board or its authorized agent.

10.36(1) Schedule I and II records. Records of controlled substances listed in Schedules I and II shall be maintained separately from all other records of the registrant.

10.36(2) Schedule III, IV, and V records. Records of controlled substances listed in Schedules III, IV, and V shall be maintained either separately from all other records of the registrant or in such form that the required information is readily retrievable from the ordinary business records of the registrant.

10.36(3) Date of record. The date on which a controlled substance is actually received, imported, distributed, exported, disposed of, or otherwise transferred shall be used as the date of receipt, importation, distribution, exportation, disposal, or transfer.

657—10.37 Reserved.

657—10.38(124) Revision of controlled substances schedules.

10.38(1) Designation of new controlled substance. The board may designate any new substance as a controlled substance to be included in any of the schedules in Iowa Code chapter 124 no sooner than 30 days following publication in the Federal Register of a final order so designating the substance under federal law. Designation of a new controlled substance under this subrule shall be temporary as provided in Iowa Code section 124.201(4).

10.38(2) Objection to designation of a new controlled substance. The board may object to the designation of any new substance as a controlled substance within 30 days following publication in the Federal Register of a final order so designating the substance under federal law. The board shall file objection to the designation of a substance as controlled, shall afford all interested parties an opportunity to be heard, and shall issue the board’s decision on the new designation as provided in Iowa Code section 124.201(4).

10.38(3) Cannabidiol investigational product. If a cannabidiol investigational product approved as a prescription drug medication by the United States Food and Drug Administration is eliminated from or revised in the federal schedule of controlled substances by the DEA and notice of the elimination or revision is given to the board, the board shall similarly eliminate or revise the prescription drug medication in the schedule of controlled substances. Such action by the board shall be immediately effective upon the date of publication of the final regulation containing the elimination or revision in the Federal Register.


10.39(1) Amend Iowa Code section 124.206(7) by adding the following new paragraph “c”:

c. Dronabinol [(±)-delta-9-tetrahydrocannabinol] in an oral solution in a drug product approved for marketing by the U.S. Food and Drug Administration.

10.39(2) Amend Iowa Code section 124.204(9) by adding the following new paragraphs:

t. Methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3,3-dimethylbutanoate, its optical, positional, and geometric isomers, salts and salts of isomers. Other names: 5F-ADB; 5F-MDMB-PINACA.

u. Methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3-methylbutanoate, its optical, positional, and geometric isomers, salts and salts of isomers. Other name: 5F-AMB.

v. N-(adamantan-1-yl)-1-(5-fluoropentyl)-1H-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts and salts of isomers. Other names: 5F-APINACA, 5F- AKB48.
w. N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)-1H-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts and salts of isomers. Other name: ADB-FUBINACA.

x. Methyl 2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido)-3,3-dimethylbutanoate, its optical, positional, and geometric isomers, salts and salts of isomers. Other names: MDMB-CHMICA, MMB-CHMINACA.

y. Methyl 2-(1-(4-fluorobenzyl)-1H-indazole-3-carboxamido)-3,3-dimethylbutanoate, its optical, positional, and geometric isomers, salts and salts of isomers. Other name: MDMB-FUBINACA.

z. N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide, its isomers, esters, ethers, salts and salts of isomers, esters and ethers. Other names: 4-fluoroisobutyryl fentanyl, para-fluoroisobutyryl fentanyl.

aa. N-(2-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)propionamide. Other names: ortho-fluoroacetamide or 2-fluoroacetamide.

ab. N-(1-phenethylpiperidin-4-yl)-N-phenyltetrahydrofuran-2-carboxamide. Other name: tetrahydrofuranyl fentanyl.

ac. 2-methoxy-N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide. Other name: methoxyacetyl fentanyl.

ad. N-(1-phenethylpiperidin-4-yl)-N-phenylacrylamide. Other names: acryl fentanyl or acryloylfentanyl.

ae. Methyl 2-(1-(4-fluorobenzyl)-1H-indazole-3-carboxamido)-3-methylbutanoate, its optical, positional, and geometric isomers, salts and salts of isomers. Other names: FUB-AMB, MMB-FUBINACA, AMB-FUBINACA.

af. N-(1-phenethylpiperidin-4-yl)-N-phenylethanolcarboxamide, its isomers, esters, ethers, salts and salts of isomers, esters, and ethers. Other name: cyclopropyl fentanyl.

ag. N-(1-phenethylpiperidin-4-yl)-N-phenylpentanamide, its isomers, esters, ethers, salts and salts of isomers, esters and ethers. Other name: valeryl fentanyl.

ah. N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)butyramide, its isomers, esters, ethers, salts and salts of isomers, esters and ethers. Other name: para-fluorobutyryl fentanyl.

ai. N-(4-methoxyphenyl)-N-(1-phenethylpiperidin-4-yl)butyramide, its isomers, esters, ethers, salts and salts of isomers, esters and ethers. Other name: para-methoxybutyryl fentanyl.

aj. N-(4-chlorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide, its isomers, esters, ethers, salts and salts of isomers, esters and ethers. Other name: para-chloroisobutyryl fentanyl.

ak. N-(1-phenethylpiperidin-4-yl)-N-phenylisobutyramide, its isomers, esters, ethers, salts and salts of isomers, esters and ethers. Other name: isobutyryl fentanyl.

al. N-(1-phenethylpiperidin-4-yl)-N-phenylethanolcarboxamide, its isomers, esters, ethers, salts and salts of isomers, esters and ethers. Other name: cyclopentyl fentanyl.

am. N-(2-fluorophenyl)-2-methoxy-N-(1-phenethylpiperidin-4-yl)acetamide, its isomers, esters, ethers, salts and salts of isomers, esters and ethers. Other name: ocfentanil.

an. Any fentanyl-related substance that is not currently listed in any schedule of the Controlled Substances Act (CSA) and its isomers, esters, ethers, salts and salts of isomers, esters and ethers. Other name: fentanyl.

ao. Naphthalen-1-yl 1-(5-fluorobutyl)-1H-indole-3-carboxylate. Other names: NM2201 or CBL2201.

ap. N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluorobutyl)-1H-indazole-3-carboxamide. Other name: 5F-AB-PINACA.

aq. 1-(4-cyanobutyl)-N-(2-phenylpropan-2-yl)-1H-indazole-3-carboxamide. Other names: 4-CN-CUMYL-BUTINACA, 4-cyano-CUMYL-BUTINACA, 4-CN-CUMYL BINACA, CUMYL-4CN-BINACA, or SGT-78.

ar. Methyl 2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido)-3-methylbutanoate. Other names: MMB-CHMICA or AMB-CHMICA.

as. 1-(5-fluorobutyl)-N-(2-phenylpropan-2-yl)-1H-pyrrolo[2,3-b]pyridine-3-carboxamide. Other name: 5F-CUMYL-P7AICA.

10.39(3) Amend Iowa Code section 124.204(2) by adding the following new paragraph:

be. MT-45 (1-cyclohexyl-4-(1,2-diphenylethyl)piperazine).
10.39(4) Amend Iowa Code section 124.212 by adding the following new subsection “6”:

6. Approved cannabidiol drugs. A drug product in finished dosage formulation that has been approved by the U.S. Food and Drug Administration that contains cannabidiol (2-[1R-3-methyl-6R-(1-methylethenyl)-2-cyclohexen-1-yl]-5-pentyl-1,3-benzenediol) derived from cannabis and no more than 0.1 percent (w/w) residual tetrahydrocannabinols.

10.39(5) Amend Iowa Code section 124.204(6) “i” by adding the following new subparagraph:

(27) 1-(1,3-benzodioxol-5-yl)-2-(ethylamino)-pentan-1-one. Other names: N-ethylpentylone or ephylone.

[ARC 3345C, IAB 9/27/17, effective 11/1/17; ARC 3860C, IAB 6/20/18, effective 7/25/18; ARC 3984C, IAB 8/29/18, effective 10/3/18; ARC 4085C, IAB 10/24/18, effective 10/3/18; ARC 4269C, IAB 1/30/19, effective 3/6/19; ARC 4455C, IAB 5/22/19, effective 6/26/19]

657—10.40(124) Excluded and exempt substances. The Iowa board of pharmacy hereby excludes from all schedules the current list of “Excluded Nonnarcotic Products” identified in Title 21, CFR Part 1308, Section 22. With the exception of Excluded Nonnarcotic Products, the board hereby excludes from all schedules the current list of “Exempted Prescription Products” described in Title 21, CFR Part 1308, Section 32. Copies of such lists may be obtained by written request to the board office at 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688.

[ARC 3345C, IAB 9/27/17, effective 11/1/17; ARC 4455C, IAB 5/22/19, effective 6/26/19]

657—10.41(124) Anabolic steroid defined. Anabolic steroid, as defined in Iowa Code section 126.2(2), includes any substance identified as such in Iowa Code section 124.208(6) or 126.2(2).

[ARC 3345C, IAB 9/27/17, effective 11/1/17]

657—10.42(124B) Additional precursor substances. Pursuant to Iowa Code section 124B.2(2), the list of precursor substances identified in Iowa Code section 124B.2(1) is amended by adding the following new paragraph:

ab. Alpha-phenylacetoacetamitrole and its salts, optical isomers, and salts of optical isomers. Other name: APAAN.

[ARC 3860C, IAB 6/20/18, effective 7/25/18]

657—10.43(124) Reporting discipline and criminal convictions. A registrant shall provide written notice to the board of any disciplinary or enforcement action imposed by any licensing or regulatory authority on any license or registration held by the registrant no later than 30 days after the final action. Discipline may include, but is not limited to, fine or civil penalty, citation or reprimand, probationary period, suspension, revocation, and voluntary surrender. A registrant shall provide written notice to the board of any criminal conviction of the registrant or of any owner that is related to the operation of the registered location no later than 30 days after the conviction. The term criminal conviction includes instances when the judgment of conviction or sentence is deferred.

[ARC 3345C, IAB 9/27/17, effective 11/1/17]

657—10.44(124) Discipline. Pursuant to 657—Chapter 36, the board may fine, suspend, revoke, or impose other disciplinary sanctions on a registrant for any of the following:

1. Any violation of the federal Food, Drug, and Cosmetic Act or federal regulations promulgated under the Act.
2. Any conviction of a crime related to controlled substances committed by the registrant, or if the registrant is an association, joint stock company, partnership, or corporation, by any managing officer.
3. Refusing access to the registered location or registrant records to an agent of the board for the purpose of conducting an inspection or investigation.
4. Failure to maintain registration pursuant to 657—Chapter 10.
5. Any violation of Iowa Code chapter 124, 124B, 126, 155A, or 205, or any rule of the board, including the disciplinary grounds set forth in 657—Chapter 36.

[ARC 3345C, IAB 9/27/17, effective 11/1/17; ARC 3857C, IAB 6/20/18, effective 7/25/18]

These rules are intended to implement Iowa Code sections 124.201, 124.301 to 124.308, 124.402, 124.403, 124.501, 126.2, 126.11, 147.88, 155A.13, 155A.17, 155A.26, 155A.37, and 205.3.
[Filed 9/29/71; amended 8/9/72, 12/15/72, 11/14/73, 8/14/74, 4/8/75]
[Filed 11/24/76, Notice 10/20/76—published 12/15/76, effective 1/19/77]
[Filed 11/9/77, Notice 8/24/77—published 11/30/77, effective 1/4/78]
[Filed 10/20/78, Notices 8/9/78, 9/6/78—published 11/15/78, effective 1/9/79]
[Filed 2/12/81, Notice 12/24/80—published 3/4/81, effective 7/1/81]
[Filed 7/24/81, Notice 5/13/81—published 8/19/81, effective 9/23/81]
[Filed emergency 12/14/81—published 1/6/82, effective 1/6/82]
[Filed emergency 10/6/82—published 10/27/82, effective 10/27/82]
[Filed 6/16/83, Notice 5/11/83—published 7/6/83, effective 8/10/83]
[Filed 2/23/84, Notice 11/23/83—published 3/14/84, effective 4/18/84]
[Filed emergency 8/10/84—published 8/29/84, effective 8/10/84]
[Filed emergency 6/14/85—published 7/3/85, effective 6/14/85]
[Filed emergency 8/30/85—published 9/25/85, effective 9/6/85]
[Filed emergency 12/4/85—published 1/1/86, effective 12/5/85]
[Filed emergency 5/14/86—published 6/4/86, effective 5/16/86]
[Filed 1/28/87, Notice 11/19/86—published 2/25/87, effective 4/1/87]
[Filed emergency 7/24/87—published 8/12/87, effective 7/24/87]
[Filed 8/5/87, Notice 6/3/87—published 8/26/87, effective 9/30/87]
[Filed emergency 1/21/88—published 2/10/88, effective 1/22/88]
[Filed emergency 8/5/88—published 8/24/88, effective 8/5/88]
[Filed emergency 10/13/88—published 11/2/88, effective 10/13/88]
[Filed emergency 5/16/89—published 6/14/89, effective 5/17/89]
[Filed emergency 9/12/89—published 10/4/89, effective 9/13/89]
[Filed 1/19/90, Notice 11/29/89—published 2/7/90, effective 3/14/90]
[Filed 8/31/90, Notice 6/13/90—published 9/19/90, effective 10/24/90]
[Filed emergency 1/29/91—published 2/20/91, effective 2/27/91]
[Filed 1/29/91, Notice 9/19/90—published 2/20/91, effective 3/27/91]
[Filed emergency 2/27/91—published 3/20/91, effective 2/27/91]
[Filed 4/26/91, Notice 2/20/91—published 5/15/91, effective 6/19/91]
[Filed emergency 5/10/91—published 5/29/91, effective 5/10/91]
[Filed 7/30/91, Notice 5/29/91—published 8/21/91, effective 9/25/91]³
[Filed emergency 9/23/91—published 10/16/91, effective 9/23/91]
[Filed emergency 10/18/91—published 11/13/91, effective 10/21/91]
[Filed 3/12/92, Notice 1/8/92—published 4/1/92, effective 5/6/92]
[Filed 5/21/92, Notice 4/1/92—published 6/10/92, effective 7/15/92]
[Filed emergency 8/10/92—published 9/2/92, effective 8/10/92]
[Filed 10/22/92, Notice 9/2/92—published 11/11/92, effective 1/1/93]
[Filed 9/23/93, Notice 5/26/93—published 10/13/93, effective 11/17/93]
[Filed 3/22/95, Notice 11/9/94—published 4/12/95, effective 5/31/95]
[Filed 12/6/95, Notice 8/16/95—published 1/3/96, effective 2/7/96]⁴
[Filed 11/19/97, Notice 10/8/97—published 12/17/97, effective 1/21/98]
[Filed 7/31/98, Notice 5/20/98—published 8/26/98, effective 9/30/98]
[Filed emergency 8/18/99—published 9/8/99, effective 8/18/99]
[Filed emergency 7/18/00—published 8/9/00, effective 7/18/00]
[Filed 8/14/02, Notice 6/12/02—published 9/4/02, effective 10/9/02]
[Filed emergency 12/13/02—published 1/8/03, effective 12/13/02]
[Filed emergency 7/16/04 after Notice 6/9/04—published 8/4/04, effective 7/16/04]
[Filed 10/22/04, Notice 3/31/04—published 11/10/04, effective 12/15/04]
[Filed emergency 5/3/05—published 5/25/05, effective 5/21/05]
[Filed emergency 6/30/05 after Notice 5/11/05—published 7/20/05, effective 7/1/05]
[Filed 8/9/05, Notice 5/25/05—published 8/31/05, effective 10/5/05]
[Filed 3/22/06, Notice 12/21/05—published 4/12/06, effective 5/17/06]
[Filed 3/22/06, Notice 1/18/06—published 4/12/06, effective 5/17/06]
[Filed 5/17/06, Notice 4/12/06—published 6/7/06, effective 7/12/06]
[Filed 2/7/07, Notice 10/25/06—published 2/28/07, effective 4/4/07]
[Filed 5/14/07, Notice 2/28/07—published 6/6/07, effective 7/11/07]
[Filed emergency 8/2/07—published 8/29/07, effective 8/2/07]
[Filed emergency 11/13/07 after Notice 8/29/07—published 12/5/07, effective 11/13/07]
[Filed ARC 7636B (Notice ARC 7448B, IAB 12/31/08), IAB 3/11/09, effective 4/15/09]
[Filed Emergency ARC 7906B, IAB 7/1/09, effective 6/22/09]
[Filed ARC 8172B (Notice ARC 7908B, IAB 7/1/09), IAB 9/23/09, effective 10/28/09]
[Filed Emergency ARC 8411B, IAB 12/30/09, effective 12/1/09]
[Filed ARC 8539B (Notice ARC 8269B, IAB 11/4/09), IAB 2/24/10, effective 4/1/10]
[Filed ARC 8892B (Notice ARC 8667B, IAB 4/7/10), IAB 6/30/10, effective 9/1/10]
[Filed Emergency ARC 8989B, IAB 8/11/10, effective 7/21/10]
[Filed Emergency ARC 9000B, IAB 8/11/10, effective 7/22/10]
[Filed Emergency ARC 9091B, IAB 9/22/10, effective 8/30/10]
[Filed ARC 9410B (Notice ARC 9196B, IAB 11/3/10), IAB 3/9/11, effective 4/13/11]
[Filed ARC 9912B (Notice ARC 9671B, IAB 8/10/11), IAB 12/14/11, effective 1/18/12]
[Filed ARC 0504C (Notice ARC 0351C, IAB 10/3/12), IAB 12/12/12, effective 1/16/13]
[Filed ARC 0749C (Notice ARC 0652C, IAB 3/20/13), IAB 5/29/13, effective 7/3/13]
[Filed Emergency ARC 0893C, IAB 8/7/13, effective 7/9/13]
[Filed Emergency ARC 1408C, IAB 4/2/14, effective 3/13/14]
[Filed ARC 1575C (Notice ARC 1407C, IAB 4/2/14), IAB 8/20/14, effective 9/24/14]
[Filed ARC 1787C (Notice ARC 1647C, IAB 10/1/14), IAB 12/10/14, effective 1/14/15]
[Filed ARC 2195C (Notice ARC 2064C, IAB 7/22/15), IAB 10/14/15, effective 11/18/15]
[Filed ARC 2407C (Notice ARC 2287C, IAB 12/9/15), IAB 2/17/16, effective 3/23/16]
[Filed ARC 2408C (Notice ARC 2285C, IAB 12/9/15), IAB 2/17/16, effective 3/23/16]
[Filed ARC 3100C (Notice ARC 2858C, IAB 12/7/16), IAB 6/7/17, effective 7/12/17]
[Filed ARC 3345C (Notice ARC 3136C, IAB 6/21/17), IAB 9/27/17, effective 11/1/17]
[Filed ARC 3743C (Notice ARC 3505C, IAB 12/20/17), IAB 4/11/18, effective 5/16/18]
[Filed ARC 3857C (Notice ARC 3506C, IAB 12/20/17), IAB 6/20/18, effective 7/25/18]
[Filed ARC 3859C (Notice ARC 3511C, IAB 12/20/17), IAB 6/20/18, effective 7/25/18]
[Filed ARC 3860C (Notice ARC 3701C, IAB 3/28/18), IAB 6/20/18, effective 7/25/18]
[Filed ARC 3984C (Notice ARC 3758C, IAB 4/25/18), IAB 8/29/18, effective 10/3/18]
[Filed Emergency ARC 4085C, IAB 10/24/18, effective 10/3/18]
[Filed ARC 4269C (Notice ARC 4086C, IAB 10/24/18), IAB 1/30/19, effective 3/6/19]
[Filed ARC 4455C (Notice ARC 4290C, IAB 2/13/19), IAB 5/22/19, effective 6/26/19]
[Filed ARC 4580C (Notice ARC 4386C, IAB 4/10/19), IAB 7/31/19, effective 9/4/19]

0 Two or more ARCs
1 Effective date delayed 70 days by the Administrative Rules Review Committee at its meeting held September 11, 1991.
CHAPTER 21
ELECTRONIC DATA AND AUTOMATED SYSTEMS IN PHARMACY PRACTICE

657—21.1(124,155A) Purpose and scope. The purpose of this chapter is to provide the minimum standards for the utilization of electronic data and automated systems in the practice of pharmacy and shall apply to all pharmacies located in Iowa.

657—21.2(124,155A) Definitions. For the purpose of this chapter, the following definitions shall apply:

“Automated data processing system” means an application that is used for prescription, patient, drug, and prescriber information; installed on a pharmacy’s computer or server; and controlled by the pharmacy.

“Automated medication distribution system” or “AMDS” includes, but is not limited to, an automated device or series of devices operated by an electronic interface with one or more computers that is used to prepare, package, or dispense specified dosage units of drugs for administration or dispensing. “AMDS” does not include electronic storage devices that do not have an electronic interface with one or more computers of the pharmacy. 

“CSA” means the Iowa uniform controlled substances Act.

“CSA registration” means the registration issued by the board pursuant to the CSA that signifies the registrant’s authorization to engage in registered activities with controlled substances.

“DEA” means the U.S. Department of Justice, Drug Enforcement Administration.

“Electronically prepared prescription” means a prescription that is generated utilizing an electronic prescription application.

“Electronic device” means an electronic, mechanical, or other device which is used to intercept communications and includes but is not limited to network, file and print servers; desktop workstations; laptop computers; tablets; mini-computers; smart phones; and similar devices.

“Electronic prescription” means an electronically prepared prescription that is authorized and transmitted from the prescriber to the pharmacy by means of electronic transmission.

“Electronic prescription application” means software that is used to create electronic prescriptions and that is intended to be installed on a prescriber’s computers and servers where access and records are controlled by the prescriber.

“Electronic signature” means a confidential personalized digital key, code, number, or other method used for secure electronic data transmissions which identifies a particular person as the source of the message, authenticates the signatory of the message, and indicates the person’s approval of the information contained in the transmission.

“Electronic transmission” means the transmission of an electronic prescription, formatted as an electronic data file, from a prescriber’s electronic prescription application to a pharmacy’s computer, where the data file is imported into the pharmacy prescription application.

“Facsimile transmission” or “fax transmission” means the transmission of a digital image of a prescription from the prescriber or the prescriber’s agent to the pharmacy. “Facsimile transmission” includes but is not limited to transmission of a written prescription between the prescriber’s fax machine and the pharmacy’s fax machine; transmission of an electronically prepared prescription from the prescriber’s electronic prescription application to the pharmacy’s fax machine or printer; or transmission of an electronically prepared prescription from the prescriber’s fax machine to the pharmacy’s fax machine, computer, or printer.

“Intermediary” means any technology system that receives and transmits an electronic prescription between the prescriber and the pharmacy.

“Pharmacist verification” or “verified by a pharmacist” means the accuracy of a prescription drug is verified by a pharmacist, pharmacist-intern, or technician in an approved tech-check-tech program.

“Prescription drug order” or “prescription” means a lawful order of a practitioner for a drug or device for a specific patient that is communicated to a pharmacy, regardless of whether the communication is oral, electronic, via facsimile, or in printed form.
“Readily retrievable” means that hard-copy or electronic records can be separated out from all other records within 48 hours of a request from the board or other authorized agent.

“Written prescription” means a prescription that is created on paper, a prescription that is electronically prepared and printed, or a prescription that is electronically prepared and transmitted from the prescriber’s electronic device to a pharmacy via facsimile. A written prescription for a controlled substance shall be manually signed by the prescriber in compliance with federal and state laws, rules, and regulations.

[ARC 3640C, IAB 2/14/18, effective 3/21/18; ARC 4580C, IAB 7/31/19, effective 9/4/19]

657—21.3(124,155A) System security and safeguards. To maintain the integrity and confidentiality of patient records and prescription drug orders, any system, computer, or electronic device utilized shall have adequate security including system safeguards designed to prevent and detect unauthorized access, modification, or manipulation of patient records and prescription drug orders. Authentication credentials shall be securely maintained by the individual to whom the credentials are issued and shall not be shared with or disclosed to any other individual. Once a drug or device has been dispensed, any alterations in either the prescription drug order data or the patient record shall be documented and shall include the identification of all pharmacy personnel who were involved in making the alteration as well as the responsible pharmacist. An automated data processing system used for the receipt and processing of electronic transmissions from a prescriber’s electronic prescription application shall comply with DEA requirements relating to electronic prescriptions and shall be certified compliant with DEA regulations.

[ARC 3640C, IAB 2/14/18, effective 3/21/18]

657—21.4 Reserved.

657—21.5(124,155A) Automated data processing systems. An automated data processing system may be used, subject to the requirements contained in this rule, for the storage and retrieval of prescription, patient, prescriber and drug data as well as data relating to the pharmacy staff utilization of the system.

21.5(1) Electronic storage of hard-copy prescriptions. A pharmacy that maintains an electronic copy of an original hard-copy prescription for a noncontrolled substance shall retain, in a readily retrievable format, the original hard-copy prescription as required in rule 657—6.8(155A) but shall be exempt from the requirement to record on the original hard-copy prescription the date and unique identification number of the prescription.

21.5(2) Data retrievable and printable. Any automated data processing system shall be capable of immediate retrieval (via computer monitor or hard-copy printout) of, at a minimum, any prescription, patient, prescriber, and drug data as well as data relating to pharmacy staff utilization of the system.

21.5(3) Auxiliary procedure for system downtime. A pharmacy utilizing an automated data processing system shall have a procedure that will maintain security and confidentiality of all data as well as ensure the legal dispensing of any prescription drug order in the event the system experiences downtime.

[ARC 3640C, IAB 2/14/18, effective 3/21/18]

657—21.6(124,155A) Electronic prescription applications. Beginning January 1, 2020, each prescription for a controlled substance shall be transmitted electronically to a pharmacy except as provided in rule 657—21.8(124,155A). Prior to January 1, 2020, a prescriber may, but shall not be required to, initiate and authorize a prescription drug order utilizing an electronic prescription application that has been determined to maintain security and confidentiality of patient information and records and, if prescribing controlled substances via an electronic prescribing system, certified compliant with DEA regulations for electronic prescribing of controlled substances. The prescription drug order shall contain all information required by Iowa Code sections 155A.27 and 147.107(5). The receiving pharmacist shall be responsible for verifying the authenticity of an electronically prescribed prescription pursuant to rule 657—8.19(124,126,155A). A prescription that is electronically generated prior to January 1, 2020, or subject to exemption as provided in rule 657—21.8(124,155A), may be
transmitted to a pharmacy via electronic or facsimile transmission or printed in hard-copy format for delivery to the pharmacy. A prescription that is transmitted by a prescriber’s agent via electronic or facsimile transmission shall include the first and last names and title of the agent responsible for the transmission.

**21.6(1) Electronic transmission.** Beginning January 1, 2020, a prescription prepared pursuant to this rule shall be transmitted electronically to a pharmacy, unless exempt pursuant to rule 657—21.8(124,155A). A pharmacy shall be certified compliant with DEA regulations relating to electronic prescriptions prior to electronically receiving prescriptions for controlled substances. The electronic record shall serve as the original record and shall be maintained for two years from the date of last activity on the prescription. Any annotations shall be made and retained on the electronic record.

a. An electronically prepared and transmitted prescription that is printed following transmission shall be clearly labeled as a copy, not valid for dispensing.

b. The authenticity of a prescription transmitted via electronic transmission between a DEA-certified electronic prescription application and a DEA-certified electronic automated data processing system shall be deemed verified by virtue of the security processes included in those applications.

c. A pharmacy shall ensure that no intermediary has the ability to change the content of the prescription drug order or compromise its confidentiality during the transmission process. The electronic format of the prescription drug order may be changed by the intermediary to facilitate the transmission between electronic applications as long as the content of the prescription drug order remains unchanged.

d. In addition to the information requirements for a prescription, an electronically transmitted prescription shall identify the transmitter’s telephone number for verbal confirmation, the time and date of transmission, and the pharmacy intended to receive the transmission as well as any other information required by federal or state laws, rules, or regulations.

e. If the transmission of an electronic prescription fails, the prescriber may print the prescription, manually sign the printed prescription, and deliver the prescription to the pharmacy via facsimile transmission in accordance with subrule 21.6(2).

**21.6(2) Printed (hard-copy) prescriptions.** A prescription electronically generated prior to January 1, 2020, or a prescription that is exempt from the electronic prescription mandate as provided in rule 657—21.8(124,155A), may be printed in hard-copy format for facsimile transmission or delivery to the pharmacy.

a. A prescription for a controlled substance shall include the prescriber’s manual signature. Printed or hard-copy prescriptions for Schedule II controlled substances shall not be transmitted to a pharmacy via facsimile transmission, except as authorized in rule 657—21.7(124,155A).

b. If the prescriber authenticates a prescription for a noncontrolled prescription drug utilizing an electronic signature, the printed prescription shall be printed on security paper. Security features of the paper shall ensure that prescription information is not obscured or rendered illegible when transmitted via facsimile or when scanned into an electronic record system.

c. If the facsimile transmission of a printed prescription is a result of a failed electronic transmission, the facsimile shall indicate that it was originally transmitted to the named pharmacy, the date and time of the original electronic transmission, and the fact that the original transmission failed.

[ARC 3640C, IAB 2/14/18, effective 3/21/18; ARC 4580C, IAB 7/31/19, effective 9/4/19]

**657—21.7(124,155A) Facsimile transmission of a prescription.** A pharmacist may dispense noncontrolled and controlled drugs, including Schedule II controlled substances only as provided in this rule, pursuant to a prescription faxed to the pharmacy by the prescribing practitioner or the practitioner’s agent. The means of transmission via facsimile shall ensure that prescription information is not obscured or rendered illegible due to security features of the paper utilized by the prescriber to prepare a written prescription. The faxed prescription shall serve as the original record, except as provided in subrule 21.7(1), shall be maintained for a minimum of two years from the date of the last activity on the prescription, and shall contain all information required by Iowa Code sections 155A.27 and 147.107(5), including the prescriber’s signature. If the prescription is transmitted by an agent of
the prescriber, the facsimile transmission shall include the first and last names and title of the agent responsible for the transmission. The pharmacist shall be responsible for verifying the authenticity of the prescription as to the source of the facsimile transmission.

21.7(1) Schedule II controlled substances—emergency situations. A pharmacist may, in an emergency situation as defined in 657—subrule 10.26(1), dispense a Schedule II controlled substance pursuant to a facsimile transmission to the pharmacy of a written, signed prescription from the prescriber or the prescriber’s agent pursuant to the requirements of rule 657—10.26(124). The facsimile shall serve as the temporary written record required by 657—subrule 10.26(2).

21.7(2) Schedule II controlled substances—compounded injectable. A prescription for a Schedule II narcotic substance to be compounded for the direct administration to a patient by parenteral, intravenous, intramuscular, subcutaneous, or intraspinal infusion may be transmitted by a prescriber or the prescriber’s agent to a pharmacy via facsimile.

21.7(3) Schedule II controlled substances—long-term care facility patients. A prescription for any Schedule II controlled substance for a resident of a long-term care facility, as “long-term care facility” is defined in rule 657—23.1(155A), may be transmitted by the prescriber or the prescriber’s agent to a pharmacy via facsimile. The prescription shall identify that the patient is a resident of a long-term care facility.

21.7(4) Schedule II controlled substances—hospice patients. A prescription for any Schedule II controlled substance for a patient in a hospice program licensed pursuant to Iowa Code chapter 135J or a program certified or paid for by Medicare under Title XVIII may be transmitted via facsimile by the prescriber or the prescriber’s agent to the pharmacy. The prescription shall identify that the patient is a hospice patient.

[ARC 3640C, IAB 2/14/18, effective 3/21/18]

657—21.8(124,155A) Electronic prescription mandate and exemptions. Beginning January 1, 2020, all prescriptions shall be transmitted electronically to a pharmacy except as provided in this rule.

21.8(1) Prescriptions exempt. Prescriptions which shall be exempt from electronic transmission include:

a. A prescription for a patient residing in a nursing home, long-term care facility, correctional facility, or jail.
b. A prescription authorized by a licensed veterinarian.
c. A prescription for a device.
d. A prescription dispensed by a department of veterans affairs pharmacy.
e. A prescription requiring information that makes electronic transmission impractical, such as complicated or lengthy directions for use or attachments.
f. A prescription for a compounded preparation containing two or more components.
g. A prescription issued in response to a public health emergency in a situation where a non-patient-specific prescription would be permitted.
h. A prescription issued for an opioid antagonist pursuant to Iowa Code section 135.190 or a prescription issued for epinephrine pursuant to Iowa Code section 135.185.
i. A prescription issued during a temporary technical or electronic failure at the location of the prescriber or pharmacy, provided that a prescription issued pursuant to this paragraph shall indicate on the prescription that the prescriber or pharmacy is experiencing a temporary technical or electronic failure.
j. A prescription issued pursuant to an established and valid collaborative practice agreement, standing order, or drug research protocol.
k. A prescription issued in an emergency situation pursuant to federal law and regulation and rules of the board. An emergency situation may include, but is not limited to, the issuance of a prescription to meet the immediate care need of a patient after hours when a prescriber is unable to access electronic prescribing capabilities. Such prescription shall be limited to a quantity sufficient to meet the acute need of the patient with no authorized refills.

21.8(2) Prescriber, medical group, institution, or pharmacy exemption. A prescriber, medical group, institution, or pharmacy which has been granted an exemption to the electronic prescription mandate
pursuant to rule 657—21.9(124,155A) shall be exempt from the electronic prescription mandate only for the duration of the approved exemption. Upon expiration of an approved exemption, the prescriber, medical group, institution, or pharmacy shall either comply with the electronic prescription mandate or timely petition the board for renewal of the exemption pursuant to rule 657—21.9(124,155A).

[Arc 4580C, IAB 7/31/19, effective 9/4/19]

657—21.9(124,155A) Exemption from electronic prescription mandate—petition. A prescriber, medical group, institution, or pharmacy that is unable to comply with the electronic prescription mandate in rule 657—21.8(124,155A) prior to January 1, 2020, may petition the board, on forms provided by the board, for an exemption from the requirements based upon economic hardship; technical limitations that the prescriber, medical group, institution, or pharmacy cannot control; or other exceptional circumstances. A prescriber, medical group, institution, or pharmacy seeking an exemption beginning January 1, 2020, shall submit a completed petition no later than October 1, 2019. A timely petition for renewal of a previously approved exemption shall be submitted at least 60 days in advance of the expiration of the previously approved exemption.

21.9(1) Petition information. A petition for exemption from the electronic prescription mandate shall include, but not be limited to, all of the following:

a. The name and address of the prescriber, medical group, institution, or pharmacy seeking the exemption. For medical groups and institutions, a list of the names, professional license numbers, and CSA registration numbers of all prescribers who would be covered by the exemption.

b. Whether the petitioner is seeking an exemption for controlled substance prescriptions, non-controlled substance prescriptions, or both.

c. The petitioner’s current electronic prescribing capabilities.

d. The reason, such as economic hardship, technological limitations, or other exceptional circumstances, the petitioner is seeking exemption.

e. Supporting documentation to justify the reason for the exemption, including the following mandatory documentation:

(1) For economic hardship petitions, a copy of the petitioner’s most recent tax return showing annual income and at least two quotes documenting the cost of implementing electronic prescribing.

(2) For technological limitation petitions, documentation showing the available Internet service providers, the speed and bandwidth available from each provider, and any data caps imposed by the Internet service provider, and documentation showing the minimum technological requirements from at least two electronic prescribing platform vendors.

f. Anticipated date of compliance with the electronic prescription mandate.

g. If the petition seeks renewal of a previously approved exemption, information relating to the petitioner’s actions during the previous exemption period to work toward compliance with the electronic prescription mandate or an explanation as to why no progress has been made.

21.9(2) Criteria for board consideration of a petition. The board shall consider all information provided in a petition seeking exemption to the electronic prescription mandate and shall approve or deny a petition for exemption based on the following criteria:

a. If the reason for exemption is economic hardship, whether the cost of compliance with the electronic prescription mandate would exceed 5 percent of the petitioner’s annual income as reported on the petitioner’s most recent tax return.

b. If the reason for exemption is technological limitations, whether the Internet service providers available have the technological capabilities required by the electronic prescribing platform.

c. If the reason for exemption is other exceptional circumstances, examples of exceptional circumstances include, but are not limited to, whether the petitioner is a free or low-income clinic, whether the petitioner had a bankruptcy in the previous year, whether the petitioner intends to discontinue practice in Iowa prior to December 31, 2020, and whether the petitioner has a disability that limits the ability to utilize an electronic prescribing platform. All other exceptional circumstances will be evaluated on a case-by-case basis.
d. If the petition seeks renewal of a previous exemption to the electronic prescription mandate, the number of exemptions previously granted and updated information as it relates to the petitioner working toward compliance with the electronic prescription mandate or the explanation as to why no progress has been made.

21.9(3) Duration of approved exemption. The board may approve an exemption, or the renewal of an exemption, to the electronic prescription mandate for a specified period of time not to exceed one year from the date of approval.

[ARC 4580C, IAB 7/31/19, effective 9/4/19]

657—21.10(124,155A) Automated medication distribution system (AMDS). Any pharmacy that utilizes an AMDS shall comply with these rules in addition to all applicable federal and state laws, rules, and regulations.

21.10(1) Policies and procedures. Pursuant to the requirements regarding policies and procedures in 657—subrule 8.3(5), each pharmacy utilizing an AMDS shall have policies and procedures that address all aspects of the operation of the AMDS to include, at a minimum:

a. Access to drugs and patient information,
b. Pharmacy personnel training in the proper operation of the AMDS,
c. Methods to ensure accurate stocking of the AMDS pursuant to subrule 21.10(2),
d. Confidentiality of patient information,
e. Routine and preventative maintenance of the AMDS according to manufacturer recommendations,
f. Packaging and labeling of prescription drugs loaded into or dispensed from the AMDS that is in compliance with federal and state laws, rules, and regulations, and

g. Security and control of the prescription drugs maintained and utilized in the AMDS to include:
   (1) Drug loading, storage, and records.
   (2) Drugs removed from system components but not used.
   (3) Inventory.
   (4) Cross contamination.
   (5) Lot number control.
   (6) Wasted or discarded drugs.
   (7) Controlled substances.

21.10(2) Stocking the AMDS. The pharmacy shall have adequate procedures in place to ensure the accurate stocking of drugs into an AMDS using barcode scanning technology. Only a pharmacy technician, pharmacist-intern, or pharmacist shall be allowed to participate in the stocking of the AMDS.

21.10(3) Pharmacist verification of drugs dispensed from AMDS.

a. When an AMDS only dispenses drugs that were prepackaged and verified by a pharmacist prior to being stocked in the AMDS and there was no further manipulation of the drug or package other than affixing a patient-specific label, such drugs shall not require additional pharmacist verification prior to administration or dispensing to the patient or authorized representative.

b. When a drug is stocked in an AMDS and undergoes further manipulation, such as counting and packaging, such drugs shall require pharmacist verification prior to dispensing to the patient. Such verification shall be documented.

21.10(4) Placement of AMDS.

a. An AMDS placed outside a pharmacist’s direct supervision shall only dispense pharmacist-verified packages in compliance with paragraph 21.10(3)’a.’

b. An AMDS that manipulates, including but not limited to counting, packaging, or labeling, prescription drugs for subsequent patient dispensing shall only be utilized in a pharmacy under the direct supervision of a pharmacist, except in an approved telepharmacy pursuant to 657—Chapter 13.

[ARC 3640C, IAB 2/14/18, effective 3/21/18]

657—21.11(124,155A) Pharmacist verification of controlled substance fills—daily printout or logbook. The individual pharmacist who makes use of the pharmacy prescription application shall provide documentation of the fact that the fill information entered into the pharmacy prescription
application each time the pharmacist fills a prescription order for a controlled substance is correct. If
the pharmacy prescription application provides a hard-copy printout of each day’s controlled substance
prescription order fill data, that printout shall be verified, dated, and signed by each individual
pharmacist who filled a controlled substance prescription order. Each individual pharmacist must verify
that the data indicated is correct and sign this document in the same manner as the pharmacist would
sign a check or legal document (e.g., J. H. Smith or John H. Smith). This document shall be maintained
in a separate file at that pharmacy for a period of two years from the dispensing date. This printout
of the day’s controlled substance prescription order fill data shall be generated by and available at
each pharmacy using a computerized pharmacy prescription application within 48 hours of the date on
which the prescription was dispensed. The printout shall be verified and signed by each pharmacist
involved with such dispensing. In lieu of preparing and maintaining printouts as provided above, the
pharmacy may maintain a bound logbook or separate file. The logbook or file shall include a statement
signed each day by each individual pharmacist involved in each day’s dispensing that attests to the
fact that the prescription information entered into the pharmacy prescription application that day has
been reviewed by the pharmacist and is correct as shown. Pharmacist statements shall be signed in the
manner previously described. The logbook or file shall be maintained at the pharmacy for a period of
two years after the date of dispensing.

[ARC 3640C, IAB 2/14/18, effective 3/21/18]

These rules are intended to implement Iowa Code sections 124.301, 124.306, 124.308, 147.107,
155A.27, 155A.33, and 155A.35.

[Filed 9/16/97, Notice 7/16/97—published 10/8/97, effective 11/12/97]
[Filed 7/31/98, Notice 5/20/98—published 8/26/98, effective 9/30/98]
[Filed 8/14/02, Notice 6/12/02—published 9/4/02, effective 10/9/02]
[Filed 10/22/04, Notice 3/31/04—published 11/10/04, effective 12/15/04]
[Filed 6/2/05, Notice 1/19/05—published 6/22/05, effective 7/27/05]
[Filed 6/2/05, Notice 3/16/05—published 6/22/05, effective 7/27/05]
[Filed 2/7/07, Notice 10/25/06—published 2/28/07, effective 4/4/07]
[Filed 8/3/07, Notice 6/20/07—published 8/29/07, effective 10/3/07]
[Filed ARC 7636B (Notice ARC 7448B, IAB 12/31/08), IAB 3/11/09, effective 4/15/09]
[Filed ARC 8171B (Notice ARC 7910B, IAB 7/1/09), IAB 9/23/09, effective 10/28/09]
[Filed ARC 9912B (Notice ARC 9671B, IAB 8/10/11), IAB 12/14/11, effective 1/18/12]
[Filed ARC 2639C (Notice ARC 2498C, IAB 4/13/16), IAB 8/3/16, effective 9/7/16]
[Filed ARC 3345C (Notice ARC 3136C, IAB 6/21/17), IAB 9/27/17, effective 11/1/17]
[Filed ARC 3640C (Notice ARC 3329C, IAB 9/27/17), IAB 2/14/18, effective 3/21/18]
[Filed ARC 4580C (Notice ARC 4386C, IAB 4/10/19), IAB 7/31/19, effective 9/4/19]
CHAPTER 25
CHLD SUPPORT NONCOMPLIANCE

657—25.1(252J) Definitions. For the purpose of this chapter the following definitions shall apply:
    “Act” means Iowa Code chapter 252J.
    “Board” means the Iowa board of pharmacy.
    “Certificate” means a document known as a certificate of noncompliance which is provided by the
child support unit certifying that the named licensee is not in compliance with a support order or with a
written agreement for payment of support entered into by the child support unit and the licensee.
    “Child support unit” means the child support recovery unit of the Iowa department of human
services.
    “Denial notice” means a board notification denying an application for the issuance or renewal of a
license as required by the Act.
    “License” means a license to practice pharmacy, a registration to practice as a pharmacist-intern, a
registration to practice as a pharmacy technician, a registration to practice as a pharmacy support person,
or a registration to possess, prescribe, dispense, administer, distribute, or otherwise handle controlled
substances under Iowa Code chapter 124.
    “Licensee” means an individual to whom a license has been issued or who is seeking the issuance
of a license.
    “Revocation or suspension notice” means a board notification suspending a license for an indefinite
or specified period of time or a notification revoking a license as required by the Act.
    “Withdrawal certificate” means a document known as a withdrawal of a certificate of noncompliance
provided by the child support unit certifying that the certificate is withdrawn and that the board may
proceed with issuance, reinstatement, or renewal of a license.
[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 3346C, IAB 9/27/17, effective 11/1/17]

657—25.2(252J) Issuance or renewal of license—denial. The board shall deny the issuance or renewal
of a license upon the receipt of a certificate from the child support unit. This rule shall apply in addition
to the procedures set forth in the Act.
    25.2(1) Service of denial notice. Notice shall be served upon the licensee by certified mail, return
receipt requested; by personal service; or through authorized counsel.
    25.2(2) Effective date of denial. The effective date of the denial of issuance or renewal of a license,
as specified in the notice, shall be 60 days following service of the notice upon the licensee.
    25.2(3) Preparation and service of denial notice. The executive director of the board is authorized
to prepare and serve the notice upon the licensee.
    25.2(4) Licensee responsible to inform board. Licensees shall keep the board informed of all court
actions and all child support unit actions taken under or in connection with the Act and shall provide the
board with copies, within seven days of filing or issuance, of all applications filed with the district court
pursuant to the Act, all court orders entered in such actions, and any withdrawal certificates issued by
the child support unit.
    25.2(5) Reinstatement following license denial. All board fees required for application, license
renewal, or license reinstatement shall be paid by licensees before a license will be issued, renewed, or
reinstated after the board has denied the issuance or renewal of a license pursuant to the Act.
    25.2(6) Effect of filing in district court. In the event a licensee files a timely district court action
following service of a notice, the board shall continue with the intended action described in the notice
upon the receipt of a court order lifting the stay, dismissing the action, or otherwise directing the board
to proceed. For purposes of determining the effective date of the denial of the issuance or renewal of
a license, the board shall count the number of days before the action was filed and the number of days
after the action was disposed of by the court.
    25.2(7) Final notification. The board shall notify the licensee in writing through regular first-class
mail, or such other means as the board determines appropriate in the circumstances, within ten days
of the effective date of the denial of the issuance or renewal of a license and shall similarly notify the licensee if the license is issued or renewed following the board’s receipt of a withdrawal certificate.

[ARC 3346C, IAB 9/27/17, effective 11/1/17]

657—25.3(252J) Suspension or revocation of a license. The board shall suspend or revoke a license upon the receipt of a certificate from the child support unit according to the procedures set forth in the Act. This rule shall apply in addition to the procedures set forth in the Act.

25.3(1) Service of revocation or suspension notice. Revocation or suspension notice shall be served upon the licensee by certified mail, return receipt requested; by personal service; or through authorized counsel.

25.3(2) Effective date of revocation or suspension. The effective date of the suspension or revocation of a license, as specified in the revocation or suspension notice, shall be 60 days following service of the revocation or suspension notice upon the licensee.

25.3(3) Preparation and service of revocation or suspension notice. The executive director of the board is authorized to prepare and serve the revocation or suspension notice upon the licensee and is directed to notify the licensee that the license will be suspended unless the license is already suspended on other grounds. In the event that the license is on suspension, the executive director shall notify the licensee of the board’s intention to revoke the license.

25.3(4) Licensee responsible to inform board. The licensee shall keep the board informed of all court actions and all child support unit action taken under or in connection with the Act and shall provide the board with copies, within seven days of filing or issuance, of all applications filed with the district court pursuant to the Act, all court orders entered in such actions, and any withdrawal certificates issued by the child support unit.

25.3(5) Reinstatement following license suspension, revocation, or denial of renewal. A licensee shall pay all board fees required for license renewal or license reinstatement, and all continuing education requirements shall be met, before a license will be reinstated after the board has suspended a license pursuant to the Act. A licensee whose license to practice pharmacy has been revoked shall complete the examination components as indicated in 657—subrule 2.4(1) and shall pay all required examination fees pursuant to 657—subrule 2.5(3). A licensee whose registration to practice as a pharmacist-intern, as a pharmacy technician, or as a pharmacy support person or whose registration to handle controlled substances under Iowa Code chapter 124 has been revoked shall complete the appropriate application and pay all board fees required for new registration.

25.3(6) Effect of filing in district court. In the event a licensee files a timely district court action pursuant to the Act and following service of a revocation or suspension notice, the board shall continue with the intended action described in the revocation or suspension notice upon the receipt of a court order lifting the stay, dismissing the action, or otherwise directing the board to proceed. For purposes of determining the effective date of the suspension or revocation, the board shall count the number of days before the action was filed and the number of days after the action was disposed of by the court.

25.3(7) Final notification. The board shall notify the licensee in writing through regular first-class mail, or such other means as the board determines appropriate in the circumstances, within ten days of the effective date of the suspension or revocation of a license and shall similarly notify the licensee if a license is reinstated following the board’s receipt of a withdrawal certificate.

[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 3346C, IAB 9/27/17, effective 11/1/17; ARC 4579C, IAB 7/31/19, effective 9/4/19]

657—25.4(17A,22,252J) Share information. Notwithstanding any statutory confidentiality provision, the board may share information with the child support unit through manual or automated means for the sole purpose of identifying applicants or licensees subject to enforcement under the Act.

These rules are intended to implement Iowa Code chapter 252J.

[Filed 5/1/96, Notice 1/3/96—published 5/22/96, effective 6/26/96]
[Filed 2/22/99, Notice 10/21/98—published 3/10/99, effective 4/14/99]
[ Filed ARC 8673B (Notice ARC 8380B, IAB 12/16/09), IAB 4/7/10, effective 6/1/10]
[Filed ARC 3346C (Notice ARC 3133C, IAB 6/21/17), IAB 9/27/17, effective 11/1/17]
[Filed ARC 4579C (Notice ARC 4391C, IAB 4/10/19), IAB 7/31/19, effective 9/4/19]
CHAPTER 31
STUDENT LOAN DEFAULT OR NONCOMPLIANCE
WITH AGREEMENT FOR PAYMENT OF OBLIGATION
Rescinded **ARC 4581C**, IAB 7/31/19, effective 9/4/19
CHAPTER 32
NONPAYMENT OF STATE DEBT

657—32.1(272D) Definitions. For the purpose of this chapter, the following definitions shall apply:

“Act” means Iowa Code chapter 272D.

“Board” means the Iowa board of pharmacy.

“Certificate” means a document known as a certificate of noncompliance provided by the unit certifying that the named licensee has outstanding liability placed with the unit and has not entered into an approved payment plan to pay the liability.

“Denial notice” means a board notification denying an application for the issuance or renewal of a license as required by the Act.

“Liability” means a debt or obligation placed with the unit for collection that is greater than $1000. For purposes of this chapter, “liability” does not include support payments collected pursuant to Iowa Code chapter 252J.

“License” means a license to practice pharmacy, a registration to practice as a pharmacist-intern, a registration to practice as a pharmacy technician, a registration to practice as a pharmacy support person, or a registration to possess, prescribe, dispense, administer, distribute, or otherwise handle controlled substances under Iowa Code chapter 124.

“Licensee” means an individual to whom a license has been issued or who is seeking the issuance of a license.

“Revocation or suspension notice” means a board notification suspending a license for an indefinite or specified period of time or a notification revoking a license as required by the Act.

“Unit” means the centralized collection unit of the department of revenue.

“Withdrawal certificate” means a document known as a withdrawal of a certificate of noncompliance provided by the unit certifying that the certificate is withdrawn and that the board may proceed with issuance, reinstatement, or renewal of a license.

[ARC 8673B, IAB 4/7/10, effective 6/1/10]

657—32.2(272D) Issuance or renewal of a license—denial. The board shall deny the issuance or renewal of a license upon receipt of a certificate from the unit according to the procedures set forth in the Act.

32.2(1) Service of denial notice. Notice shall be served upon the licensee by restricted certified mail, return receipt requested, or by personal service in accordance with the Iowa Rules of Civil Procedure. Alternatively, the licensee may accept service personally or through authorized counsel.

32.2(2) Effective date of denial. The effective date of the denial of issuance or renewal of a license, as specified in the notice, shall be 60 days following service of the notice upon the licensee.

32.2(3) Preparation and service of denial notice. The executive director of the board is authorized to prepare and serve the notice upon the licensee.

32.2(4) Licensee responsible to inform board. Licensees shall keep the board informed of all court actions and all unit actions taken under or in connection with the Act and shall provide the board copies, within seven days of filing or issuance, of all applications filed with the district court pursuant to Iowa Code section 272D.9, all court orders entered in such actions, and any withdrawal certificates issued by the unit.

32.2(5) Reinstatement following license denial. All board fees required for application, license renewal, or license reinstatement shall be paid by the licensee and all continuing education requirements shall be met before a license will be issued, renewed, or reinstated after the board has denied the issuance or renewal of a license pursuant to the Act.

32.2(6) Effect of filing in district court. In the event a licensee timely files a district court action following service of a board notice pursuant to Iowa Code sections 272D.8 and 272D.9, the board shall continue with the intended action described in the notice upon the receipt of a court order lifting the stay, dismissing the action, or otherwise directing the board to proceed. For purposes of determining the
effective date of the denial of the issuance or renewal of a license, the board shall count the number of
days before the action was filed and the number of days after the action was disposed of by the court.

32.2(7) Final notification. The board shall notify the licensee in writing through regular first-class
mail, or such other means as the board deems appropriate in the circumstances, within ten days of the
effective date of the denial of the issuance or renewal of a license and shall similarly notify the licensee
when the license is issued or renewed following the board’s receipt of a withdrawal certificate.

657—32.3(272D) Suspension or revocation of a license. The board shall suspend or revoke a license
upon receipt of a certificate from the unit according to the procedures set forth in the Act. This rule shall
apply in addition to the procedures set forth in the Act.

32.3(1) Service of revocation or suspension notice. Notice shall be served upon the licensee by
restricted certified mail, return receipt requested, or by personal service in accordance with the Iowa
Rules of Civil Procedure. Alternatively, the licensee may accept service personally or through authorized
counsel.

32.3(2) Effective date of revocation or suspension. The effective date of the revocation or suspension
of a license, as specified in the notice, shall be 60 days following service of the notice upon the licensee.

32.3(3) Preparation and service of revocation or suspension notice. The executive director of the
board is authorized to prepare and serve the notice upon the licensee and is directed to notify the licensee
that the license will be suspended unless the license is already suspended on other grounds. In the event
that the license is on suspension, the executive director shall notify the licensee of the board’s intention
to revoke the license.

32.3(4) Licensee responsible to inform board. Licensees shall keep the board informed of all court
actions and all unit actions taken under or in connection with the Act and shall provide the board copies,
within seven days of filing or issuance, of all applications filed with the district court pursuant to Iowa
Code section 272D.9, all court orders entered in such actions, and any withdrawal certificates issued by
the unit.

32.3(5) Reinstatement following license suspension, revocation, or denial of renewal. All board
fees required for license renewal or license reinstatement shall be paid by the licensee and all continuing
education requirements shall be met before a license will be renewed or reinstated after the board
has suspended a license pursuant to the Act. A licensee whose license to practice pharmacy has been
revoked shall complete the examination components as indicated in 657—subrule 2.4(1) and shall pay
all required examination fees pursuant to 657—subrule 2.5(3). A licensee whose registration to practice
as a pharmacist-intern, as a pharmacy technician, or as a pharmacy support person or whose registration
to handle controlled substances under Iowa Code chapter 124 has been revoked shall complete the
appropriate application and pay all board fees required for new registration.

32.3(6) Effect of filing in district court. In the event a licensee timely files a district court action
following service of a board notice pursuant to Iowa Code sections 272D.8 and 272D.9, the board shall
continue with the intended action described in the notice upon the receipt of a court order lifting the
stay, dismissing the action, or otherwise directing the board to proceed. For purposes of determining
the effective date of the suspension or revocation of a license, the board shall count the number of days
before the action was filed and the number of days after the action was disposed of by the court.

32.3(7) Final notification. The board shall notify the licensee in writing through regular first-class
mail, or such other means as the board deems appropriate in the circumstances, within ten days of the
effective date of the suspension or revocation of a license and shall similarly notify the licensee when
the license is reinstated following the board’s receipt of a withdrawal certificate.

[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 4579C, IAB 7/31/19, effective 9/4/19]

657—32.4(17A,22,272D) Share information. Notwithstanding any statutory confidentiality provision,
the board may share information with the unit through manual or automated means for the sole purpose
of identifying applicants or licensees subject to enforcement under the Act.

These rules are intended to implement Iowa Code chapter 272D.

[Filed 11/24/08, Notice 10/8/08—published 12/17/08, effective 1/21/09]
[Filed ARC 8673B (Notice ARC 8380B, IAB 12/16/09), IAB 4/7/10, effective 6/1/10]
[Filed ARC 4579C (Notice ARC 4391C, IAB 4/10/19), IAB 7/31/19, effective 9/4/19]
CHAPTER 33
MILITARY SERVICE AND VETERAN RECIPROCITY

657—33.1(85GA,ch1116) Definitions. For the purposes of this chapter, the following definitions shall apply:

“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.

“Military service applicant” means an individual requesting credit toward licensure or registration requirements for education, training, or service obtained or completed in military service.

“Spouse” means a spouse of an active duty member of the military forces of the United States.

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

[ARC 1789C, IAB 12/10/14, effective 1/14/15; ARC 4582C, IAB 7/31/19, effective 9/4/19]

657—33.2(85GA,ch1116) Military education, training, and service credit. A military service applicant may apply for credit for verified military education, training, or service toward any experiential or educational requirement for pharmacist licensure, pharmacist-intern registration, or technician registration by submitting a military service credit application form to the board office. The board shall make available an application for military service credit.

33.2(1) Military service credit application. A military service credit application may be submitted with an application for licensure, examination, or registration or may be submitted prior to the submission of an application for licensure, examination, or registration. No fee is required with submission of a military service credit application.

33.2(2) Credit identified. The applicant shall identify the experiential or educational licensure or registration requirement to which the credit would be applied if granted. Credit shall not be applied to an examination requirement.

33.2(3) Submission of verification documentation. The applicant shall provide documents, military transcripts, a certified affidavit, or forms that verify completion of the relevant military education, training, or service, which may include, when applicable, the applicant’s Certificate of Release or Discharge from Active Duty (DD Form 214) or Verification of Military Experience and Training (VMET) (DD Form 2586).

33.2(4) Credit determination. Upon receipt of a completed military service credit application, the board shall promptly determine whether the verified military education, training, or service will satisfy all or any part of the identified experiential or educational qualifications for licensure or registration.

33.2(5) Granting of credit. The board shall grant credit requested in the application in whole or in part if the board determines that the verified military education, training, or service satisfies all or part of the experiential or educational qualifications for licensure or registration.

33.2(6) Notification of credit determination. The board shall inform the military service applicant in writing of the credit, if any, given toward an experiential or educational qualification for licensure or registration or explain why no credit was granted. The applicant may request reconsideration of the board’s determination upon submission of additional documentation or information.

33.2(7) Consideration of applications. The board shall grant or deny the military service credit application prior to ruling on the application for licensure, examination, or registration. The applicant shall not be required to submit any fees in connection with the license or registration application until the board issues a determination on the military service credit application. If the board does not grant the military service credit application, the applicant may withdraw any license or registration application and application fee, if submitted, or the applicant may request that the application be placed in pending status. The withdrawal of a license or registration application and fee shall not preclude subsequent applications supported by additional documentation or information.

[ARC 1789C, IAB 12/10/14, effective 1/14/15]
657—33.3(85GA,ch1116) Veteran or spouse licensure or registration. A veteran or spouse with an unrestricted pharmacist license in another jurisdiction may apply for pharmacist licensure in Iowa by license transfer pursuant to rule 657—2.9(147,155A) and this chapter. A veteran or spouse must pass any required examinations to be eligible for pharmacist licensure by license transfer. A veteran or spouse may submit an application for pharmacist-intern registration pursuant to 657—Chapter 4 and this chapter. A veteran or spouse may submit an application for technician registration pursuant to 657—Chapter 3 and this chapter. A veteran or spouse may submit an application for pharmacy support person registration pursuant to 657—Chapter 5 and this chapter.

33.3(1) Priority application status. A fully completed application for licensure or registration submitted by a veteran or spouse under this chapter shall be given priority status and shall be expedited.

33.3(2) Application requirements. Such an application shall contain all of the information required of all applicants for licensure or registration who hold unrestricted licenses or registrations in other jurisdictions and who are applying for licensure or registration, including, but not limited to, completion of all required forms, payment of applicable fees, disclosure of criminal or disciplinary history, and, if applicable, a criminal history background check. In addition, the applicant shall provide such documentation as is reasonably needed to verify the applicant’s status as a veteran under Iowa Code section 35.1(2) or as a spouse of an active duty member of the military forces of the United States.

33.3(3) Equivalency determination. Upon receipt of a fully completed application for licensure or registration, the board shall promptly determine if the requirements for licensure or registration of the jurisdiction where the veteran or spouse is licensed or registered are substantially equivalent to the requirements for licensure or registration in Iowa. The board may consider the following factors in determining substantial equivalence: scope of practice, education and coursework, degree requirements, and postgraduate experiences.

33.3(4) Licensure or registration approval. The board shall promptly grant a license or registration, as appropriate, to the veteran or spouse if the applicant is licensed or registered in another jurisdiction whose licensure or registration requirements are substantially equivalent to those required in Iowa, unless the applicant is ineligible for licensure or registration based on other grounds, for example, the applicant’s disciplinary or criminal background.

33.3(5) Notification of additional requirements and provisional licensure or registration. If the board determines that the veteran or spouse is licensed or registered in another jurisdiction whose licensure or registration requirements are not substantially equivalent to those required in Iowa, the board shall promptly inform the applicant of the additional experience, education, or examinations required for licensure or registration in Iowa. Unless the applicant is ineligible for licensure or registration based on other grounds, such as disciplinary or criminal background, the following shall apply:

a. If the applicant has not passed the required examination(s) for licensure or registration, the applicant may request that the application be placed in pending status. The board may issue a provisional 90-day license in order for a pharmacist who has applied for license transfer pursuant to rule 657—2.9(147,155A) to take and pass the multistate pharmacy jurisprudence examination (MPJE), Iowa Edition.

b. If additional experience or education is required in order for the applicant’s qualifications to be considered substantially equivalent, the applicant may request that the board issue a provisional license or registration for a specified period of time upon such conditions as the board deems reasonably necessary to protect the health, welfare, and safety of the public unless the board determines that the deficiency is of a character that the public health, welfare, or safety will be adversely affected if a provisional license or registration is granted.

c. If a request for a provisional license or registration is denied, the board shall issue an order fully explaining the decision and shall inform the applicant of the steps the applicant may take in order to receive a provisional license or registration.

d. If a provisional license or registration is issued, the application for full licensure or registration shall be placed in pending status until the necessary experience or education has been successfully
completed or the provisional license or registration expires, whichever occurs first. The board may extend a provisional license or registration on a case-by-case basis for good cause.

[ARC 1789C, IAB 12/10/14, effective 1/14/15; ARC 4582C, IAB 7/31/19, effective 9/4/19]

657—33.4(85GA,ch1116) Request for contested case. A military service applicant or a veteran or spouse who is aggrieved by the board’s decision to deny all or part of the military service credit application, a request for a license transfer, a request for a registration, or a request for provisional license or registration, or is aggrieved by the terms under which a provisional license or registration will be granted, may request a contested case (administrative hearing) and may participate in a contested case by telephone. A request for a contested case shall be made within 30 days of issuance of the board’s decision pursuant to 657—subrule 35.30(1). There shall be no fees or costs assessed against the military service applicant, veteran or spouse in connection with a contested case conducted pursuant to this chapter.

[ARC 1789C, IAB 12/10/14, effective 1/14/15; ARC 4582C, IAB 7/31/19, effective 9/4/19]

These rules are intended to implement 2014 Iowa Acts, chapter 1116, section 34.

[Filed ARC 1789C (Notice ARC 1641C, IAB 10/1/14), IAB 12/10/14, effective 1/14/15]
[Filed ARC 4582C (Notice ARC 4483C, IAB 6/5/19), IAB 7/31/19, effective 9/4/19]
CHAPTER 36
DISCIPLINE

657—36.1(147,155A,272C) Authority. The board has the authority to impose discipline for any violations of Iowa Code chapters 124, 124B, 126, 147, 155A, 205, and 272C or the rules promulgated thereunder.

[ARC 3344C, IAB 9/27/17, effective 1/1/17]

657—36.2(147,155A,272C) Definitions. For purposes of this chapter:

“Board” means the Iowa board of pharmacy.

“License” means any license, registration, or permit issued by the board, regardless of whether the license, registration, or permit is active.

“Licensee” means any person or entity possessing a license, registration, or permit issued by the board, regardless of whether the license, registration, or permit is active.

[ARC 3344C, IAB 9/27/17, effective 1/1/17]

657—36.3(147,155A,272C) Complaints, investigations, and board action.

36.3(1) General. The board may, upon receipt of a written or verbal complaint or upon its own motion pursuant to other evidence received by the board, review and investigate alleged acts or omissions that may violate the board’s rules or that are related to the ethical or professional conduct of a licensee.

36.3(2) Confidentiality of investigative files. Complaint files, investigation files, and all other investigation reports and investigative information in the possession of the board or its employees or agents that relate to licensee discipline shall be confidential pursuant to Iowa Code section 272C.6(4).

36.3(3) Investigation of allegations. In order to determine if probable cause exists for a disciplinary hearing, the board, the executive director, or someone designated by the executive director shall cause an investigation to be made into the allegations of the complaint. The licensee that is the subject of the complaint shall be given a reasonable opportunity to present to the investigator a position or defense respecting the allegations of the complaint prior to the commencement of a contested case.

36.3(4) Investigatory subpoena powers. The board is authorized by law to subpoena books, papers, records, and any other real evidence, whether or not privileged or confidential under law, which are necessary for the board to decide whether to institute a contested case proceeding. The issuance of investigative subpoenas is governed by rule 657—36.4(17A,147,152,272C).

36.3(5) Investigative report. Upon completion of the investigation, the investigator(s) shall prepare a report for the board’s consideration. The report may contain evidence gathered by the investigator, findings made by the investigator, the licensee’s response to the allegations, and the applicable laws or rules alleged to have been violated.

36.3(6) Board consideration. The board shall review all investigations. Participation in the review of investigative materials shall not bar any board member from participating in any subsequent disciplinary proceeding.

a. Board action. After reviewing an investigation, the board may institute a disciplinary proceeding by filing one or more statements of charges, approve a combined statement of charges and settlement agreement, send a confidential letter of education or administrative warning to the licensee, request additional investigation, including peer review, refer the case to another regulatory authority with jurisdiction over the issue, or close the case without further investigation.

b. Confidential action. If the board determines that formal disciplinary action is not warranted, the board may send a confidential letter of education or administrative warning to the licensee. The purpose of a confidential letter of education or administrative warning is to alert the licensee to possible violations of Iowa law or board rules so that the licensee may address the issues. Confidential letters of education and administrative warnings do not constitute formal disciplinary action and are not open for inspection under Iowa Code chapter 22. The board shall maintain a copy of the confidential letter of education or administrative warning in the confidential investigative file regarding the licensee.
Confidential letters of education and administrative warnings may be used as evidence against a licensee in future administrative hearings.
[ARC 3344C, IAB 9/27/17, effective 11/1/17]

657—36.4(17A,147,152,272C) Issuance of investigatory subpoenas. The board shall have the authority to issue an investigatory subpoena in accordance with the provisions of Iowa Code section 17A.13.

36.4(1) Justification. The executive director or designee may, upon the written request of a board investigator or on the executive director’s own initiative, subpoena books, papers, records and other real evidence which are necessary for the board to decide whether to institute a contested case proceeding. In the case of a subpoena for mental health records, each of the following conditions shall be satisfied prior to the issuance of the subpoena:
   a. The nature of the complaint reasonably justifies the issuance of a subpoena;
   b. Adequate safeguards have been established to prevent unauthorized disclosure;
   c. An express statutory mandate, articulated public policy, or other recognizable public interest favors access; and
   d. An attempt was made to notify the patient and to secure an authorization from the patient for release of the records at issue.

36.4(2) Contents of request. A written request for a subpoena or the executive director’s written memorandum in support of the issuance of a subpoena shall contain the following:
   a. The name and address of the person to whom the subpoena will be directed;
   b. A specific description of the books, papers, records or other real evidence requested;
   c. An explanation of why the documents sought to be subpoenaed are necessary for the board to determine whether it should institute a contested case proceeding; and
   d. In the case of a subpoena request for mental health records, confirmation that the conditions described in subrule 36.4(1) have been satisfied.

36.4(3) Contents of subpoena. Each subpoena shall contain the following:
   a. The name and address of the person to whom the subpoena is directed;
   b. A description of the books, papers, records or other real evidence requested;
   c. The date, time and location for production or inspection and copying;
   d. The time within which a motion to quash or modify the subpoena must be filed;
   e. The signature, address and telephone number of the executive director or designee;
   f. The date of issuance;
   g. A return of service.

36.4(4) Motion to quash or modify. Any person who is aggrieved or adversely affected by compliance with the subpoena and who desires to challenge the subpoena must, within 14 days after service of the subpoena, or before the time specified for compliance if such time is less than 14 days, file with the board a motion to quash or modify the subpoena. The motion shall describe the legal reasons why the subpoena should be quashed or modified and may be accompanied by legal briefs or factual affidavits.

36.4(5) Timely filing of motion. Upon receipt of a timely motion to quash or modify a subpoena, the board may request an administrative law judge to issue a decision or the board may issue a decision. Oral argument may be scheduled at the discretion of the board or the administrative law judge. The administrative law judge or the board may quash or modify the subpoena, deny the motion, or issue an appropriate protective order.

36.4(6) Appeal of administrative law judge ruling. A person aggrieved by a ruling of an administrative law judge who desires to challenge that ruling must appeal the ruling to the board by filing a notice of appeal with the board within ten days after service of the decision of the administrative law judge in accordance with rule 657—35.17(17A,272C).

36.4(7) Judicial review. If the person contesting the subpoena is not the person under investigation, the board’s decision is final for purposes of judicial review. If the person contesting the subpoena is the person under investigation, the board’s decision is not final for purposes of judicial review until either
657—36.5(147,272C) Peer review committee. Any case may be referred to peer review for evaluation of the professional services rendered by the licensee.

36.5(1) Contract and case referral. The board shall enter into a contract with peer reviewers to provide peer review services. The board or board staff shall determine which peer reviewer(s) will review a case and what investigative information shall be referred to a peer reviewer.

36.5(2) Written opinion. Peer reviewers shall review the information provided by the board and provide a written report to the board. The written report shall contain an opinion of the peer reviewer regarding whether the licensee conformed to minimum standards of acceptable and prevailing practice of pharmacy and the rationale supporting the opinion.

36.5(3) Confidentiality. Peer reviewers shall observe the confidentiality requirements imposed by Iowa Code section 272C.6(4).

36.5(4) Board review and action. The board shall review the committee’s findings and proceed with action available under subrule 36.3(6).

657—36.6(147,155A,272C) Grounds for discipline. The board may impose any of the disciplinary sanctions set forth in rule 657—36.7(147,155A,272C) when the board determines that the licensee has committed any of the following acts or omissions:

36.6(1) Fraud in procuring a license. Fraud in procuring a license includes but is not limited to an intentional perversion of the truth in making application for a license to practice pharmacy, to operate a pharmacy doing business in this state, or to operate as a wholesale drug distributor doing business in this state, or in making application for a registration to practice as a pharmacist-intern, a pharmacy technician, or a pharmacy support person. Fraud in procuring a license includes false representations of a material fact, whether by word or conduct, by false or misleading allegations, or by concealment of that which should have been disclosed when making application, or attempting to file or filing with the board any false or forged diploma, certificate, affidavit, identification, or qualification in making application for a license or registration in this state.

36.6(2) Professional incompetency. Professional incompetency includes but is not limited to:

a. A substantial lack of knowledge or ability to discharge professional obligations within the scope of the pharmacist’s practice.

b. A substantial deviation by a pharmacist from the standards of learning or skill ordinarily possessed and applied by other pharmacists in the state of Iowa acting in the same or similar circumstances.

c. A failure by a pharmacist to exercise in a substantial respect that degree of care which is ordinarily exercised by the average pharmacist in the state of Iowa acting under the same or similar circumstances.

d. A willful or repeated departure from, or the failure to conform to, the minimal standard or acceptable and prevailing practice of pharmacy in the state of Iowa.

36.6(3) Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of pharmacy or engaging in unethical conduct or practice harmful or detrimental to the public. Proof of actual injury need not be established.

36.6(4) Habitual intoxication or addiction to the use of drugs. Habitual intoxication or addiction to the use of drugs includes, but is not limited to:

a. The inability of a licensee to practice with reasonable skill and safety by reason of the excessive use of alcohol on a continuing basis.

b. The excessive use of drugs which may impair a licensee’s ability to practice with reasonable skill or safety.
36.6(5) Conviction of a felony related to the profession or occupation of the licensee, or a conviction of a felony that would affect the licensee’s ability to practice within the licensee’s profession. A copy of the record of conviction or a plea of guilty shall be conclusive evidence.

36.6(6) Fraud in representations as to skill or ability. Fraud in representations as to skill or ability includes, but is not limited to, a pharmacist having made deceptive or untrue representations as to competency to perform professional services which the pharmacist is not qualified to perform by virtue of training or experience.

36.6(7) Use of untrue or improbable statements in advertisements.

36.6(8) Distribution of drugs for other than lawful purposes. The distribution of drugs for other than lawful purposes includes, but is not limited to, the disposition of drugs in violation of Iowa Code chapters 124, 126, and 155A.

36.6(9) Willful or repeated violations of the provisions of Iowa Code chapter 147 or 272C. Willful or repeated violations of these Acts include, but are not limited to, a licensee’s intentionally or repeatedly violating a lawful rule or regulation promulgated by the board of pharmacy or the Iowa department of public health, violating a lawful order of the board in a disciplinary hearing, or violating the provisions of title IV (public health) of the Iowa Code.

36.6(10) Violating a statute or law of this state, another state, or the United States, without regard to its designation as either a felony or misdemeanor, which statute or law relates to the practice of pharmacy or the distribution of controlled substances, prescription drugs, or nonprescription drugs.

36.6(11) Failure to notify the board within 30 days after a final decision entered by the licensing authority of another state, territory, or country which decision resulted in a license revocation, suspension, or other disciplinary sanction.

36.6(12) Knowingly aiding, assisting, procuring, or advising another person to unlawfully practice pharmacy or to unlawfully perform the functions of a pharmacist-intern, a pharmacy technician, or a pharmacy support person.

36.6(13) Inability of a licensee to practice with reasonable skill and safety by reason of mental or physical impairment or chemical abuse.

36.6(14) Being adjudged mentally incompetent by a court of competent jurisdiction. Such adjudication shall automatically suspend a license for the duration of the license or registration unless the board otherwise orders.

36.6(15) Submission of a false report of continuing education, submission of a false certification of completion of continuing education, or failure to submit biennial reports of continuing education as directed by the board.

36.6(16) Failure to notify the board within 30 days after occurrence of any judgment or settlement of a malpractice court claim or action.

36.6(17) Failure to file reports concerning acts or omissions committed by another licensee.

36.6(18) Willful or repeated malpractice.

36.6(19) Willful or gross negligence.

36.6(20) Obtaining any fee by fraud or misrepresentation.

36.6(21) Violating any of the grounds for revocation or suspension of a license or registration listed in Iowa Code section 147.55, Iowa Code chapter 155A, or any of the rules of the board.

36.6(22) Practicing pharmacy without an active and current Iowa pharmacist license, operating a pharmacy without a current pharmacy license, operating a prescription drug wholesale facility without a current wholesale drug license, operating an outsourcing facility without a current outsourcing facility license, practicing as a pharmacist-intern without a current pharmacist-intern registration, assisting a pharmacist with technical functions associated with the practice of pharmacy without a current pharmacy technician registration except as provided in the introductory paragraph of rule 657—3.3(155A), or assisting a pharmacist with nontechnical functions associated with the practice of pharmacy without a current pharmacy support person registration.

36.6(23) Attempting to circumvent the patient counseling requirements or discouraging patients from receiving patient counseling concerning their prescription drug orders.
36.6(24) Noncompliance with a child support order or with a written agreement for payment of child support as evidenced by a certificate of noncompliance issued pursuant to Iowa Code chapter 252J.

36.6(25) Engaging in any conduct that subverts or attempts to subvert a board investigation.

36.6(26) Employing or continuing to employ as a practicing pharmacist any person whose Iowa pharmacist license is not current and active, employing or continuing to employ a person to assist a pharmacist with technical functions associated with the practice of pharmacy who is not currently registered as a pharmacy technician except as provided in the introductory paragraph of rule 657—3.3(155A), or employing or continuing to employ a person to assist a pharmacist with nontechnical functions associated with the practice of pharmacy who is not currently registered as a pharmacy support person.

36.6(27) Retaliating against a pharmacist, pharmacist-intern, pharmacy technician, or pharmacy support person for making allegations of illegal or unethical activities, making required reports to the board, or cooperating with a board investigation or survey.

36.6(28) Failing to create and maintain complete and accurate records as required by state or federal law or regulation or rule of the board.

36.6(29) Violating the pharmacy or drug laws or rules of another state while under the jurisdiction of that state.

36.6(30) Having a license revoked or suspended or having other disciplinary action taken by a licensing authority of this state or of another state, territory, or country for conduct substantially equivalent to any of the grounds for disciplinary action in Iowa. A copy of the record from the licensing authority taking the disciplinary action shall be conclusive evidence of the action.

36.6(31) Failure to comply with mandatory child or dependent adult abuse reporter training requirements.

36.6(32) Failure to timely provide to the board or a representative of the board prescription fill data or other required pharmacy or controlled substances records.

36.6(33) Nonpayment of a state debt as evidenced by a certificate of noncompliance issued pursuant to Iowa Code chapter 272D.

36.6(34) Failure to notify the board of a criminal conviction relating to the practice of pharmacy or to the distribution of drugs within 30 days of the action, regardless of the jurisdiction where it occurred.

36.6(35) Obtaining, possessing, or attempting to obtain or possess prescription drugs without lawful authority.

36.6(36) Diverting prescription drugs from a pharmacy for personal use or for distribution.

36.6(37) Practicing pharmacy, or assisting in the practice of pharmacy, while under the influence of alcohol or illicit substances.

36.6(38) Practicing pharmacy, or assisting in the practice of pharmacy, while under the influence of prescription drugs or substances for which the licensee does not have a lawful prescription or while impaired by the use of legitimately prescribed pharmacological agents, drugs, or substances.

36.6(39) Forging or altering a prescription.

36.6(40) Practicing outside the scope of the profession.

36.6(41) Dispensing, or contributing to the dispensing of, an incorrect prescription, which includes, but is not limited to, the incorrect drug, the incorrect strength, the incorrect patient or prescriber, or the incorrect or incomplete directions.

36.6(42) Failing to comply with a confidential order for evaluation.

36.6(43) Failing to comply with the terms of an initial agreement or contract with the Iowa monitoring program for pharmacy professionals committee.

[ARC 3344C, IAB 9/27/17, effective 11/1/17; ARC 4581C, IAB 7/31/19, effective 9/4/19]

657—36.7(147,155A,272C) Disciplinary sanctions.

36.7(1) Possible sanctions. The board has the authority to impose the following disciplinary sanctions:

a. Revocation of a license issued by the board.
b. Suspension of a license issued by the board until further order of the board or for a specified period.
c. Nonrenewal of a license issued by the board.
d. Prohibit permanently, until further order of the board, or for a specified period, the engaging in specified procedures, methods or acts.
e. Probation.
f. Require a licensee to complete additional education or training.
g. Require a pharmacist to successfully complete any reexamination for licensure.
h. Order a licensee to undergo a physical or mental examination.
i. Impose civil penalties not to exceed $25,000.
j. Issue citation and warning.
k. Such other sanctions allowed by law as may be appropriate.

36.7(2) Considerations in determining sanctions. The board may consider the following factors in determining the nature and severity of the disciplinary sanction to be imposed:

a. The relative seriousness of the violation as it relates to assuring the citizens of this state a high standard of professional care.
b. The facts of the particular violation.
c. Any extenuating circumstances or other countervailing considerations.
d. Number of prior violations or complaints.
e. seriousness of prior violations or complaints.
f. Whether remedial action has been taken.
g. Any other factors as may reflect upon the competency, ethical standards, and professional conduct of the licensee.

[ARC 3344C, IAB 9/27/17, effective 11/1/17]

657—36.8(147,272C) Voluntary surrender. A voluntary surrender of a license may be submitted to the board as resolution of a contested case or in lieu of continued compliance with a disciplinary order of the board. A voluntary surrender, when accepted by the board, has the same force and effect as an order of revocation. The voluntary surrender of a license during the pendency of a complaint or investigation shall be considered discipline and shall have the same force and effect as an order of revocation. A request for reinstatement of a license that has been surrendered shall be handled under the terms established by rule 657—35.36(17A,147,272C).

[ARC 3344C, IAB 9/27/17, effective 11/1/17]

657—36.9(155A,272C) Order for mental or physical examination. A licensee is, as a condition of licensure, under a duty to submit to a mental or physical examination within a time period specified by order of the board. Such examination may be ordered upon a showing of probable cause and shall be at the expense of the licensee.

36.9(1) Content of order. A board order for mental or physical examination shall include the following items:

a. A description of the type of examination to which the licensee must submit.
b. The name and address of the examiner or treatment facility that the board has identified as having the potential to perform the examination.
c. The time period in which the licensee must schedule the required examination.
d. The amount of time in which the licensee is required to complete the examination.
e. A requirement that the licensee cause a report of the examination results to be provided to the board within a specified period of time.
f. A requirement that the licensee communicate with the board regarding the status of the examination.
g. A provision allowing the licensee to request additional time to schedule or complete the examination or to request that the board approve an alternative examiner or treatment facility. The board shall, in its sole discretion, determine whether to grant such a request.
36.9(2) **Objection to order.** A licensee who is the subject of a board order and who objects to the order may file a request for hearing. The request for hearing shall specifically identify the factual and legal issues upon which the licensee bases the objection. The hearing shall be considered a contested case proceeding and shall be governed by the provisions of 657—Chapter 35. A contested case involving an objection to an examination order will be captioned in the name of Jane or John Doe in order to maintain the licensee’s confidentiality.

36.9(3) **Closed hearing.** Any hearing on an objection to the board order shall be closed pursuant to Iowa Code section 272C.6(4).

36.9(4) **Order and reports—confidential.** An examination order and any subsequent examination reports issued in the course of a board investigation are confidential investigative information pursuant to Iowa Code section 272C.6(4).

[ABC 3344C; IAB 9/27/17, effective 11/1/17]

657—36.10(272C) **Disciplinary hearings—fees and costs.**

36.10(1) **Definitions.** As used in this chapter in relation to a formal disciplinary action filed by the board against a licensee:

- "**Deposition**" means the testimony of a person pursuant to subpoena or at the request of the state of Iowa taken in a setting other than a hearing.

- "**Expenses**" means costs incurred by persons appearing pursuant to subpoena or at the request of the state of Iowa for purposes of providing testimony on the part of the state of Iowa in a hearing or other official proceeding and shall include mileage reimbursement at the rate specified in Iowa Code section 70A.9 or, if commercial air or ground transportation is used, the actual cost of transportation to and from the proceeding. Also included are actual costs incurred for meals and necessary lodging.

- "**Medical examination fees**" means actual costs incurred by the board in a physical, mental, chemical abuse, or other impairment-related examination or evaluation of a licensee when the examination or evaluation is conducted pursuant to an order of the board.

- "**Transcript**" means a printed verbatim reproduction of everything said on the record during a hearing or other official proceeding.

- "**Witness fees**" means compensation paid by the board to persons appearing pursuant to subpoena or at the request of the state of Iowa, for purposes of providing testimony on the part of the state of Iowa. For the purposes of this rule, compensation shall be the same as outlined in Iowa Code section 622.69 or 622.72 as the case may be.

36.10(2) **Hearing fee and recoverable costs.** The board may charge a fee not to exceed $75 for conducting a disciplinary hearing that results in disciplinary action taken by the board against the licensee. In addition to the fee, the board may recover from the licensee costs for the following procedures and personnel:

a. Recording fees of a certified shorthand reporter.

b. Transcript.

c. Witness fees and expenses.

d. Depositions.

36.10(3) **Fees, costs as part of disciplinary order.** Fees and costs assessed by the board shall be described as part of the board’s final disciplinary order. Fees and costs that can be calculated at the time of the issuance of the board’s final disciplinary order shall be itemized in the order. Fees and costs that cannot be calculated at the time of the issuance of the board’s final disciplinary order may be invoiced to the licensee at a later time, provided that the board’s final disciplinary order states that the particular fees and costs will be invoiced at a later date. The board’s final disciplinary order and any invoices shall specify the time period in which the licensee shall pay the assessed fees and costs.

36.10(4) **Board treatment of collected fees, costs.** Fees and costs collected by the board shall be allocated to the expenditure category of the board in which the hearing costs were incurred. The fees and costs shall be considered repayment receipts as defined in Iowa Code section 8.2.
36.10(5) Failure to pay assessed fees, costs. Failure of a licensee to pay the fees and costs assessed herein within the time period specified in the board’s final disciplinary order or subsequent invoice shall constitute a violation of a lawful order of the board. [ARC 3344C, IAB 9/27/17, effective 11/1/17]

657—36.11(88GA, SF304) Prohibited grounds for discipline. The board shall not suspend or revoke the license of a person who is in default or is delinquent on repayment or a service obligation under federal or state postsecondary educational loans or public or private services-conditional postsecondary tuition assistance solely on the basis of such default or delinquency. [ARC 4581C, IAB 7/31/19, effective 9/4/19]

These rules are intended to implement Iowa Code sections 17A.10 to 17A.23, 124.304, 124B.12, 126.17, 147.55, 155A.6 to 155A.6B, 155A.12, 155A.13 to 155A.13C, 155A.15 to 155A.18, 155A.26, 205.11, 272C.3 to 272C.6, 272C.9, and 272C.10.

[Filed 2/18/00, Notice 12/15/99—published 3/22/00, effective 4/26/00]
[Filed 10/24/02, Notice 7/24/02—published 11/13/02, effective 12/18/02]
[Filed 7/15/03, Notice 4/16/03—published 8/6/03, effective 9/10/03]
[Filed 11/30/06, Notice 9/27/06—published 12/20/06, effective 1/24/07]
[Filed 3/5/08, Notice 12/19/07—published 3/26/08, effective 4/30/08]
[Filed 11/24/08, Notice 10/8/08—published 12/17/08, effective 1/21/09]

[Filed ARC 8673B (Notice ARC 8380B, IAB 12/16/09), IAB 4/7/10, effective 6/1/10]
[Filed ARC 9412B (Notice ARC 9191B, IAB 11/3/10), IAB 3/9/11, effective 4/13/11]
[Filed ARC 1963C (Notice ARC 17901C, IAB 12/10/14), IAB 4/15/15, effective 5/20/15]
[Filed ARC 3344C (Notice ARC 3135C, IAB 6/21/17), IAB 9/27/17, effective 11/1/17]
[Filed ARC 4581C (Notice ARC 4484C, IAB 6/5/19), IAB 7/31/19, effective 9/4/19]

1 April 30, 2008, effective date of 36.1(4) “i,” “v,” and “aa” delayed 70 days by the Administrative Rules Review Committee at its meeting held April 4, 2008.
CHAPTER 39
EXPANDED PRACTICE STANDARDS

657—39.1(155A) Purpose and scope. The purpose of this chapter is to establish the minimum standards for the programs and activities identified in this chapter. These rules shall apply to all licensed pharmacists, other registered pharmacy personnel, and all pharmacies, including owners, engaged in the state of Iowa in the programs and activities identified in this chapter. These rules are in addition to rules of the board relating to the practice of pharmacy unless otherwise indicated by rule.

[ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—39.2 and 39.3 Reserved.

657—39.4(155A) Pharmaceutical care. Pharmaceutical care is a comprehensive, patient-centered, outcomes-oriented pharmacy practice in which the pharmacist accepts responsibility for assisting the prescriber and the patient in optimizing the patient’s drug therapy plan and works to promote health, to prevent disease, and to optimize drug therapy. Pharmaceutical care does not include the prescribing of drugs without the consent of the prescriber.

39.4(1) Drug therapy problems. In providing pharmaceutical care, the pharmacist shall strive to identify, resolve, and prevent drug therapy problems.

39.4(2) Drug therapy plan. In providing pharmaceutical care, the pharmacist shall access and evaluate patient-specific information, identify drug therapy problems, and utilize that information in a documented plan of therapy that assists the patient or the patient’s caregiver in achieving optimal drug therapy. In concert with the patient, the patient’s prescribing practitioner, and the patient’s other health care providers, the pharmacist shall assess, monitor, and suggest modifications of the drug therapy plan as appropriate.

[ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—39.5 Reserved.

657—39.6(155A) Statewide protocols. A pharmacist may, pursuant to statewide protocols developed by the board in consultation with the department of public health and available on the board’s website at pharmacy.iowa.gov, order and dispense medications pursuant to rules 657—39.8(155A), 657—39.9(155A), and 657—39.11(155A). For the purpose of this rule, the order shall constitute a prescription.

[ARC 4270C, IAB 1/30/19, effective 3/6/19; see Delay note at end of chapter; ARC 4387C, IAB 4/10/19, effective 4/5/19; ARC 4588C, IAB 7/31/19, effective 9/4/19]

657—39.7(135,147A) Opioid antagonist dispensing by pharmacist—standing order. An authorized pharmacist may dispense an opioid antagonist pursuant to a standing order established by the department, which standing order can be found via the board’s website, or pursuant to a standing order authorized by an individual licensed health care professional in compliance with the requirements of this rule. An authorized pharmacist may only delegate the dispensing of an opioid antagonist to an authorized pharmacist-intern under the direct supervision of an authorized pharmacist. Nothing in this rule prohibits a prescriber or facility from establishing and implementing standing orders or protocols under the authority granted to the prescriber or facility.

39.7(1) Definitions. For the purposes of this rule, the following definitions shall apply:

“Authorized pharmacist” means an Iowa-licensed pharmacist who has completed the training requirements of this rule. “Authorized pharmacist” also includes an Iowa-registered pharmacist-intern who has completed the training requirements of this rule and is working under the direct supervision of an authorized Iowa-licensed pharmacist.

“Department” means the Iowa department of public health.

“First responder” means an emergency medical care provider, a registered nurse staffing an authorized service program under Iowa Code section 147A.12, a physician assistant staffing an
authorized service program under Iowa Code section 147A.13, a firefighter, or a peace officer as defined in Iowa Code section 801.4 who is trained and authorized to administer an opioid antagonist.

“Licensed health care professional” means a person licensed under Iowa Code chapter 148 to practice medicine and surgery or osteopathic medicine and surgery, an advanced registered nurse practitioner licensed under Iowa Code chapter 152 or 152E and registered with the board of nursing, or a physician assistant licensed to practice under the supervision of a physician as authorized in Iowa Code chapters 147 and 148C.

“Opioid antagonist” means the same as defined in Iowa Code section 147A.1.

“Opioid-related overdose” means the same as defined in Iowa Code section 147A.1.

“Person in a position to assist” means a family member, friend, caregiver, health care provider, employee of a substance abuse treatment facility, or other person who may be in a position to render aid to a person at risk of experiencing an opioid-related overdose.

“Recipient” means an individual at risk of an opioid-related overdose or a person in a position to assist an individual at risk of an opioid-related overdose.

“Standing order” means a preauthorized medication order with specific instructions from the licensed health care professional to dispense a medication under clearly defined circumstances.

39.7(2) Authorized pharmacist training. An authorized pharmacist shall document successful completion of an ACPE-approved continuing education program of at least one-hour duration related to opioid antagonist utilization prior to dispensing opioid antagonists pursuant to a standing order.

39.7(3) Additional supply. Notwithstanding a standing order to the contrary, an authorized pharmacist shall only dispense an opioid antagonist after completing an eligibility assessment and providing training and education to the recipient.

39.7(4) Assessment. An authorized pharmacist shall assess an individual for eligibility to receive an opioid antagonist pursuant to a standing order. In addition to the criteria identified in a standing order, an authorized pharmacist shall also take into consideration the following criteria to determine the eligibility of the recipient to receive and possess an opioid antagonist:

a. The person at risk of an opioid-related overdose for which the opioid antagonist is intended to be administered has no known sensitivity or allergy to naloxone, unless the person at risk is not known to the recipient, including but not limited to a first responder or member of law enforcement.

b. The recipient is oriented to person, place, and time and able to understand and learn the essential components of opioid-related overdose, appropriate response, and opioid antagonist administration.

39.7(5) Recipient training and education. Upon assessment and determination that an individual is eligible to receive and possess an opioid antagonist pursuant to a standing order, an authorized pharmacist shall, prior to dispensing an opioid antagonist pursuant to a standing order, provide training and education to the recipient including, but not limited to, the information identified in this subrule. An authorized pharmacist shall require the recipient to attest that, if the product will be accessible to any other individual for administration, the recipient will make available to such individual all received training and education materials. An authorized pharmacist may provide to the recipient written materials that include, but may not be limited to, the information identified in this subrule, but the written materials shall not be in lieu of direct pharmacist consultation with the recipient.

a. The signs and symptoms of opioid-related overdose as described in the standing order.

b. The importance of calling 911 as soon as possible and the potential need for rescue breathing.

c. The appropriate use and directions for administration of the opioid antagonist to be dispensed pursuant to the standing order.

d. Adverse reactions of the opioid antagonist as well as reactions resulting from opioid withdrawal following administration.

e. The proper storage conditions, including temperature excursions, of the opioid antagonist being dispensed.

f. The expiration date of the opioid antagonist being dispensed and the appropriate disposal of the opioid antagonist upon expiration.

g. The prohibition of the recipient from further distributing the opioid antagonist to another individual, unless that individual has received appropriate training and education.
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h. Information about substance abuse or behavioral health treatment programs.

39.7(6) Labeling. Upon the determination that a recipient is eligible to receive and possess an opioid antagonist, an authorized pharmacist shall label the product pursuant to rule 657—6.10(126,155A) and 657—subrule 8.19(8). An authorized pharmacist shall ensure that the labeling does not render the expiration date of the product illegible. The medication shall be dispensed in the name of the eligible recipient.

39.7(7) Reporting. A copy of the assessment form shall be submitted to the department as provided on the assessment form within seven days of the dispensing of the opioid antagonist or within seven days of a denial of eligibility.

39.7(8) Records. An authorized pharmacist shall create and maintain an original record of each individual assessment on forms provided by the board, regardless of the eligibility determination following assessment, and dispensing of opioid antagonists pursuant to a standing order. These records shall be available for inspection and copying by the board or its authorized agent for at least two years.

[ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—39.8(155A) Statewide protocol—naloxone. An authorized pharmacist may order and dispense naloxone to patients 18 years and older pursuant to a statewide protocol developed pursuant to rule 657—39.6(155A) and in compliance with this rule. An authorized pharmacist may only delegate the dispensing of naloxone to an authorized pharmacist-intern under the direct supervision of an authorized pharmacist. For the purpose of this rule, the order shall constitute a prescription.

39.8(1) Definitions. For the purposes of this rule, the following definitions shall apply:

“ACPE” means the Accreditation Council for Pharmacy Education.

“Authorized pharmacist” means an Iowa-licensed pharmacist who has completed the training requirements of this rule. “Authorized pharmacist” also includes an Iowa-registered pharmacist-intern who has completed the training requirements of this rule and is working under the direct supervision of an authorized pharmacist.

“Authorized pharmacist-intern” means an Iowa-registered pharmacist-intern who has completed the training requirements for an authorized pharmacist pursuant to this rule.

“Board” means the Iowa board of pharmacy.

“Patient” means an individual consulting with a pharmacist for drug therapy and may include an individual in a position to assist someone at risk of an opioid-related overdose.

39.8(2) Authorized pharmacist training. An authorized pharmacist shall document successful completion of an ACPE-approved continuing education program of at least one-hour duration related to naloxone utilization prior to dispensing naloxone pursuant to the statewide protocol.

39.8(3) Assessment. An authorized pharmacist shall assess a patient for eligibility to receive naloxone using criteria identified in the statewide protocol.

39.8(4) Patient education. Upon assessment and determination that a patient is eligible to receive and possess naloxone pursuant to the statewide protocol, an authorized pharmacist shall, prior to dispensing naloxone pursuant to the statewide protocol, provide training and education to the patient including, but not limited to, the information identified in this subrule. An authorized pharmacist may provide to the patient written materials that include, but may not be limited to, the information identified in this subrule, but the written materials shall not be in lieu of direct pharmacist consultation with the patient.

a. The signs and symptoms of opioid-related overdose as described in the statewide protocol.

b. The importance of calling 911 as soon as possible and the potential need for rescue breathing.

c. The appropriate use and directions for administration of the naloxone to be dispensed pursuant to the statewide protocol.

d. Adverse reactions of naloxone as well as reactions resulting from opioid withdrawal following administration.

e. The proper storage conditions, including temperature excursions, of the naloxone product being dispensed.
f. The expiration date of the naloxone product being dispensed and the appropriate disposal of the naloxone product upon expiration.

g. Information about substance abuse or behavioral health treatment programs, if applicable.

39.8(5) Labeling. Naloxone dispensed pursuant to this rule shall be labeled in accordance with rule 657—6.10(126,155A), and the labeling shall not render the expiration date of the product illegible.

39.8(6) Reporting. As soon as reasonably possible, the authorized pharmacist shall notify the patient’s primary health care provider of the naloxone product provided to the patient. If the patient does not have a primary health care provider, the authorized pharmacist shall provide the patient with a written record of the naloxone product provided to the patient and shall advise the patient to consult a physician.

39.8(7) Records. An authorized pharmacist shall maintain records of naloxone ordered and dispensed pursuant to the statewide protocol.

[ARC 4270C, IAB 1/30/19, effective 3/6/19; see Delay note at end of chapter; ARC 4387C, IAB 4/10/19, effective 4/5/19; ARC 4583C, IAB 7/31/19, effective 9/4/19]

657—39.9(155A) Statewide protocol—nicotine replacement tobacco cessation products. An authorized pharmacist may order and dispense nicotine replacement tobacco cessation products to patients 18 years and older pursuant to a statewide protocol developed pursuant to rule 657—39.6(155A) and in compliance with this rule. An authorized pharmacist may only delegate the dispensing of a nicotine replacement tobacco cessation product to an authorized pharmacist-intern under the direct supervision of an authorized pharmacist. For the purpose of this rule, the order shall constitute a prescription.

39.9(1) Definitions. For the purposes of this rule, the following definitions shall apply:

“ACPE” means the Accreditation Council for Pharmacy Education.

“Authorized pharmacist” means an Iowa-licensed pharmacist who has completed the training requirements of this rule. “Authorized pharmacist” also includes an Iowa-registered pharmacist-intern who has completed the training requirements of this rule and is working under the direct supervision of an authorized pharmacist.

“Authorized pharmacist-intern” means an Iowa-registered pharmacist-intern who has completed the training requirements for an authorized pharmacist pursuant to this rule.

“Board” means the Iowa board of pharmacy.

39.9(2) Authorized pharmacist training. An authorized pharmacist shall document successful completion of an ACPE-approved continuing education program of at least one-hour duration related to nicotine replacement tobacco cessation product utilization prior to dispensing such products under the statewide protocol.

39.9(3) Assessment. An authorized pharmacist shall assess a patient for appropriateness of receiving a nicotine replacement tobacco cessation product pursuant to the statewide protocol.

39.9(4) Patient counseling and instructions. Upon assessment and determination that provision of the nicotine replacement tobacco cessation product is appropriate pursuant to the statewide protocol, an authorized pharmacist shall, prior to dispensing such product, provide counseling and instructions to the patient pursuant to rule 657—6.14(155A).

39.9(5) Labeling. Nicotine replacement tobacco cessation products dispensed pursuant to this rule shall be labeled in accordance with rule 657—6.10(126,155A), and the labeling shall not render the expiration date of the product illegible.

39.9(6) Reporting. As soon as reasonably possible, the authorized pharmacist shall notify the patient’s primary health care provider of the nicotine replacement tobacco cessation product provided to the patient. If the patient does not have a primary health care provider, the authorized pharmacist shall provide the patient with a written record of the nicotine replacement tobacco cessation product provided to the patient and shall advise the patient to consult a physician.

39.9(7) Records. An authorized pharmacist shall maintain records of nicotine replacement tobacco cessation products ordered and dispensed pursuant to the statewide protocol.

[ARC 4270C, IAB 1/30/19, effective 3/6/19; see Delay note at end of chapter; ARC 4387C, IAB 4/10/19, effective 4/5/19; ARC 4583C, IAB 7/31/19, effective 9/4/19]
657—39.10(155A) Vaccine administration by pharmacists—physician-approved protocol. Through June 30, 2020, an authorized pharmacist may administer vaccines pursuant to protocols established by the CDC in compliance with the requirements of this rule. An authorized pharmacist may only delegate the administration of a vaccine to an authorized pharmacist-intern under the direct supervision of the authorized pharmacist.

39.10(1) Definitions. For the purposes of this rule, the following definitions shall apply:

“ACIP” means the CDC Advisory Committee on Immunization Practices.

“ACPE” means the Accreditation Council for Pharmacy Education.

“Authorized pharmacist” means an Iowa-licensed pharmacist who has met the requirements identified in subrule 39.10(2).

“Authorized pharmacist-intern” means an Iowa-registered pharmacist-intern who has met the requirements for an authorized pharmacist identified in paragraphs 39.10(2)“a” and “c.”

“CDC” means the United States Centers for Disease Control and Prevention.

“Immunization” shall have the same meaning as, and shall be interchangeable with, the term “vaccine.”

“Protocol” means a standing order for a vaccine to be administered by an authorized pharmacist.

“Vaccine” means a specially prepared antigen administered to a person for the purpose of providing immunity.

39.10(2) Authorized pharmacist training and continuing education. An authorized pharmacist shall document successful completion of the requirements in paragraph 39.10(2)“a” and shall maintain competency by completing and maintaining documentation of the continuing education requirements in paragraph 39.10(2)“b.”

a. Initial qualification. An authorized pharmacist shall have successfully completed an organized course of study in a college or school of pharmacy or an ACPE-accredited continuing education program on vaccine administration that:

1. Requires documentation by the pharmacist of current certification in basic cardiac life support through a training program designated for health care providers that includes hands-on training.
2. Is an evidence-based course that includes study material and hands-on training and techniques for administering vaccines, requires testing with a passing score, complies with current CDC guidelines, and provides instruction and experiential training in the following content areas:
   1. Standards for immunization practices;
   2. Basic immunology and vaccine protection;
   3. Vaccine-preventable diseases;
   4. Recommended immunization schedules;
   5. Vaccine storage and management;
   6. Informed consent;
   7. Physiology and techniques for vaccine administration;
   8. Pre- and post-vaccine assessment, counseling, and identification of contraindications to the vaccine;
   9. Immunization record management; and
   10. Management of adverse events, including identification, appropriate response, documentation, and reporting.

b. Continuing education. During any pharmacist license renewal period, an authorized pharmacist who engages in the administration of vaccines shall complete and document at least one hour of ACPE-approved continuing education with the ACPE topic designator “06” followed by the letter “P”.

c. Certification maintained. During any period within which the pharmacist may engage in the administration of vaccines, the pharmacist shall maintain current certification in basic cardiac life support through a training program designated for health care providers that includes hands-on training.

39.10(3) Protocol requirements. A pharmacist may administer vaccines pursuant to a protocol based on CDC recommendations. A protocol shall be unique to a pharmacy. The pharmacy shall comply with the parameters of the protocol. The prescriber who signs a protocol shall identify within the protocol,
by name or category, those pharmacists or other qualified health professionals that the prescriber is 
authorizing to administer vaccines pursuant to the protocol. A protocol:

a. Shall be signed by an Iowa-licensed prescriber practicing in Iowa.
b. Shall expire no later than one year from the effective date of the signed protocol.
c. Shall be effective for patients who wish to receive a vaccine administered by an authorized 
pharmacist, who meet the CDC recommended criteria, and who have no contraindications as published 
by the CDC.
d. Shall require the authorized pharmacist to notify the prescriber who signed the protocol within 
24 hours of a serious complication, and the pharmacist shall submit a Vaccine Advisory Event Reporting 
System (VAERS) report.
e. Shall specifically indicate whether the authorizing prescriber agrees that the administration of 
vaccines may be delegated by the authorized pharmacist to an authorized pharmacist-intern under the 
direct supervision of the authorized pharmacist.

39.10(4) Influenza and other emergency vaccines. An authorized pharmacist shall only administer 
via protocol, to patients six years of age and older, influenza vaccines and other emergency vaccines in 
response to a public health emergency.

39.10(5) Other adult vaccines. An authorized pharmacist shall only administer via protocol, to 
patients 18 years of age and older, the following vaccines:

a. A vaccine on the ACIP-approved adult vaccination schedule.
b. A vaccine recommended by the CDC for international travel.

39.10(6) Vaccines administered via prescription. An authorized pharmacist may administer any 
vaccine pursuant to a prescription or medication order for an individual patient. In case of a serious 
complication, the authorized pharmacist shall notify the prescriber who authorized the prescription 
within 24 hours and shall submit a VAERS report.

39.10(7) Verification and reporting. The requirements of this subrule do not apply to influenza 
and other emergency vaccines administered via protocol pursuant to subrule 39.10(4). An authorized 
pharmacist shall:

a. Prior to administering a vaccine identified in subrule 39.10(5) or 39.10(6), consult the statewide 
immunization registry or health information network.
b. As soon as reasonably possible following administration of a vaccine identified in subrule 
39.10(5) or 39.10(6), report the vaccine administration to the statewide immunization registry or health 
information network and to the patient’s primary health care provider, if known.

[ARC 3858C, IAB 6/20/18, effective 7/25/18; ARC 4270C, IAB 1/30/19, effective 3/6/19; see Delay note at end of chapter; ARC 
4555C, IAB 7/17/19, effective 7/1/19]

657—39.11(155A) Vaccine administration by pharmacists—statewide protocol. An authorized 
pharmacist may order and administer vaccines and immunizations pursuant to a statewide protocol 
developed pursuant to rule 657—39.6(155A) and in compliance with this rule. An authorized pharmacist 
may only delegate the ordering and administration of a vaccine to an authorized pharmacist-intern 
under the direct supervision of an authorized pharmacist. For the purpose of this rule, the order shall 
constitute a prescription.

39.11(1) Definitions. For the purposes of this rule, the following definitions shall apply:

“ACIP” means the CDC Advisory Committee on Immunization Practices.

“ACPE” means the Accreditation Council for Pharmacy Education.

“Authorized pharmacist” means an Iowa-licensed pharmacist who has met the requirements 
identified in subrule 39.11(3).

“Authorized pharmacist-intern” means an Iowa-registered pharmacist-intern who has met the 
requirements for an authorized pharmacist identified in subrule 39.11(3).

“Board” means the Iowa board of pharmacy.

“CDC” means the United States Centers for Disease Control and Prevention.

“Immunization” shall have the same meaning as, and shall be interchangeable with, the term 
“vaccine.”
“Vaccine” means a specially prepared antigen administered to a person for the purpose of providing immunity.

39.11(2) **Vaccines authorized by statewide protocol.** The vaccines authorized to be ordered and administered pursuant to the statewide protocol shall include:

a. To patients ages 18 years and older:
   (1) An immunization or vaccination recommended by ACIP in its approved vaccination schedule for adults.
   (2) An immunization or vaccination recommended by CDC for international travel.
   (3) A Tdap (tetanus, diphtheria, acellular pertussis) vaccination in a booster application.
   (4) Other emergency immunizations or vaccinations in response to a public health emergency.

b. To patients ages six months and older:
   (1) A vaccine or immunization for influenza.
   (2) Other emergency immunizations or vaccines in response to a public health emergency.

c. To patients ages 11 years and older:
   (1) The final two doses in a course of vaccinations for human papillomavirus (HPV).
   (2) Reserved.

39.11(3) **Authorized pharmacist training and continuing education.** An authorized pharmacist shall document successful completion of the requirements in paragraph 39.11(3) “a” and shall maintain competency by completing and maintaining documentation of the continuing education requirements in paragraph 39.11(3) “b.”

a. **Initial qualification.** An authorized pharmacist shall have successfully completed an organized course of study in a college or school of pharmacy or an ACPE-accredited continuing education program on vaccine administration that:

   (1) Requires documentation by the pharmacist of current certification in basic cardiac life support through a training program designated for health care providers that includes hands-on training.
   (2) Is an evidence-based course that includes study material and hands-on training and techniques for administering vaccines, requires testing with a passing score, complies with current CDC guidelines, and provides instruction and experiential training in the following content areas:
      1. Standards for immunization practices;
      2. Basic immunology and vaccine protection;
      3. Vaccine-preventable diseases;
      4. Recommended immunization schedules;
      5. Vaccine storage and management;
      6. Informed consent;
      7. Physiology and techniques for vaccine administration;
      8. Pre- and post-vaccine assessment, counseling, and identification of contraindications to the vaccine;
      9. Immunization record management; and
      10. Management of adverse events, including identification, appropriate response, documentation, and reporting.

b. **Continuing education.** During any pharmacist license renewal period, an authorized pharmacist who engages in the administration of vaccines shall complete and document at least one hour of ACPE-approved continuing education with the ACPE topic designator “06” followed by the letter “P.”

c. **Certification maintained.** During any period within which the pharmacist may engage in the administration of vaccines, the pharmacist shall maintain current certification in basic cardiac life support through a training program designated for health care providers that includes hands-on training.

39.11(4) **Assessment.** An authorized pharmacist shall assess a patient for appropriateness of receiving a vaccine pursuant to the statewide protocol.

39.11(5) **Verification and reporting.** Prior to the ordering and administration of an immunization pursuant to the statewide protocol, the authorized pharmacist shall consult and review the statewide immunization registry or health information network. As soon as reasonably possible following
administration of a vaccine, the pharmacist shall report such administration to the patient’s primary health care provider, primary physician, and a statewide immunization registry or health information network. If the 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.

[ARC 4270C, IAB 1/30/19, effective 3/6/19; see Delay note at end of chapter; ARC 4387C, IAB 4/10/19, effective 4/5/19; ARC 4583C, IAB 7/31/19, effective 9/4/19]

657—39.12 Reserved.

657—39.13(155A) Collaborative drug therapy management. An authorized pharmacist may only perform collaborative drug therapy management pursuant to protocol with an authorized provider pursuant to the requirements of this rule. The authorized provider retains the ultimate responsibility for the care of the patient. The pharmacist is responsible for all aspects of drug therapy management performed by the pharmacist.

39.13(1) Definitions. For the purpose of this rule, the following definitions shall apply:

“Authorized pharmacist” means an Iowa-licensed pharmacist whose license is in good standing and who meets the drug therapy management criteria defined in this subrule.

“Authorized provider” means an Iowa-licensed prescribing practitioner who is authorized by the practitioner’s professional licensing authority to participate in a collaborative practice agreement with an authorized pharmacist pursuant to these rules and the rules of the practitioner’s professional licensing authority. An authorized provider who executes a written protocol with an authorized pharmacist shall supervise the pharmacist’s activities involved in the overall management of patients receiving medications or disease management services under the protocol. The authorized provider may delegate only drug therapies that are in areas common to the authorized provider’s practice.

“Board” means the board of pharmacy.

“Collaborative drug therapy management” means participation by an authorized pharmacist and an authorized provider in the management of drug therapy pursuant to a written community practice protocol or a written hospital practice protocol.

“Collaborative practice” means that an authorized provider may delegate aspects of drug therapy management for the authorized provider’s patients to an authorized pharmacist through a community practice protocol. “Collaborative practice” also means that a P&T committee may authorize hospital pharmacists to perform drug therapy management for inpatients and hospital clinic patients through a hospital practice protocol.

“Community practice protocol” means a written, executed agreement entered into voluntarily between an authorized pharmacist and an authorized provider establishing drug therapy management for one or more of the pharmacist’s and authorized provider’s patients residing in a community setting. A community practice protocol shall comply with the requirements of subrule 39.13(2).

“Community setting” means a location outside a hospital inpatient, acute care setting or a hospital clinic setting. A community setting may include, but is not limited to, a home, group home, assisted living facility, correctional facility, hospice, or long-term care facility.

“Drug therapy management criteria” means one or more of the following:

1. Graduation from a recognized school or college of pharmacy with a doctor of pharmacy (Pharm.D.) degree;
2. Certification by the Board of Pharmaceutical Specialties (BPS);
3. Certification by the Commission for Certification in Geriatric Pharmacy (CCGP);
4. Successful completion of a National Institute for Standards in Pharmacist Credentialing (NISPC) disease state management examination and credentialing by the NISPC;
5. Successful completion of a pharmacy residency program accredited by the American Society of Health-System Pharmacists (ASHP); or
6. Approval by the board of pharmacy.

“Hospital clinic” means an outpatient care clinic operated and affiliated with a hospital and under the direct authority of the hospital’s P&T committee.
“Hospital pharmacist” means an Iowa-licensed pharmacist who meets the requirements for participating in a hospital practice protocol as determined by the hospital’s P&T committee.

“Hospital practice protocol” means a written plan, policy, procedure, or agreement that authorizes drug therapy management between hospital pharmacists and authorized providers within a hospital and the hospital’s clinics as developed and determined by the hospital’s P&T committee. Such a protocol may apply to all pharmacists and authorized providers at a hospital or the hospital’s clinics or only to those pharmacists and authorized providers who are specifically recognized. A hospital practice protocol shall comply with the requirements of subrule 39.13(3).

“P&T committee” means a committee of the hospital composed of physicians, pharmacists, and other health professionals that evaluates the clinical use of drugs within the hospital, develops policies for managing drug use and administration in the hospital, and manages the hospital drug formulary system.

“Therapeutic interchange” means an authorized exchange of therapeutic alternate drug products in accordance with a previously established and approved written protocol.

39.13(2) Community practice protocol.

a. An authorized pharmacist shall engage in collaborative drug therapy management with an authorized provider only under a written protocol that has been identified by topic. Protocols shall be made available upon request of the board or the licensing board of the authorized provider.

b. The community practice protocol shall include:

1. The name, signature, date, and contact information for each authorized pharmacist who is a party to the protocol and is eligible to manage the drug therapy of a patient. If more than one authorized pharmacist is a party to the agreement, the pharmacists shall work for a single licensed pharmacy and a principal authorized pharmacist shall be designated in the protocol.

2. The name, signature, date, and contact information for each authorized provider who may prescribe drugs and is responsible for supervising a patient’s drug therapy management. The authorized provider who initiates a protocol shall be considered the main caregiver for the patient respective to that protocol and shall be noted in the protocol as the principal authorized provider.

3. The name and contact information of the principal authorized provider and the principal authorized pharmacist who are responsible for development, training, administration, and quality assurance of the protocol.

4. A detailed written protocol pursuant to which the authorized pharmacist will base drug therapy management decisions for patients. The protocol shall authorize one or more of the following:

   1. Prescription drug orders. The protocol may authorize therapeutic interchange or modification of drug dosages based on symptoms or laboratory or physical findings defined in the protocol. The protocol shall include information specific to the dosage, frequency, duration, and route of administration of the drug authorized by the patient’s authorized provider. The protocol shall not authorize the pharmacist to change a Schedule II drug or to initiate a drug not included in the established protocol.

   2. Laboratory tests. The protocol may authorize the pharmacist to obtain or to conduct specific laboratory tests as long as the tests relate directly to the drug therapy management.

   3. Physical findings. The protocol may authorize the pharmacist to check certain physical findings, e.g., vital signs, oximetry, or peak flows, that enable the pharmacist to assess and adjust the drug therapy, detect adverse drug reactions, or determine if the patient should be referred back to the patient’s authorized provider for follow-up.

   4. Patient activities. The protocol may authorize the pharmacist to monitor specific patient activities.

   5. Procedures for securing the patient’s written consent. If the patient’s consent is not secured by the authorized provider, the authorized pharmacist shall secure such and notify the patient’s authorized provider within 24 hours.

   6. Circumstances that shall cause the authorized pharmacist to initiate communication with the authorized provider including but not limited to the need for new prescription orders and reports of the patient’s therapeutic response or adverse reaction.

   7. A detailed statement identifying the specific drugs, laboratory tests, and physical findings upon which the authorized pharmacist shall base drug therapy management decisions.
(8) A provision for the collaborative drug therapy management protocol to be reviewed, updated, and reexecuted or discontinued at least every two years.

(9) A description of the method the pharmacist shall use to document the pharmacist’s decisions or recommendations for the authorized provider.

(10) A description of the types of reports the authorized pharmacist is to provide to the authorized provider and the schedule by which the pharmacist is to submit these reports. The schedule shall include a time frame within which a pharmacist shall report any adverse reaction to the authorized provider.

(11) A statement of the medication categories and the type of initiation and modification of drug therapy that the provider authorizes the pharmacist to perform.

(12) A description of the procedures or plan that the pharmacist shall follow if the pharmacist modifies a drug therapy.

(13) Procedures for record keeping, record sharing, and long-term record storage.

(14) Procedures to follow in emergency situations.

(15) A statement that prohibits the authorized pharmacist from delegating drug therapy management to anyone other than another authorized pharmacist who has signed the applicable protocol.

(16) A statement that prohibits an authorized provider from delegating collaborative drug therapy management to any unlicensed or licensed person other than another authorized provider or an authorized pharmacist.

(17) A description of the mechanism for the pharmacist and the authorized provider to communicate with each other and for documentation by the pharmacist of the implementation of collaborative drug therapy.

c. Collaborative drug therapy management is valid only when initiated by a written protocol executed by at least one authorized pharmacist and at least one authorized provider.

d. The collaborative drug therapy protocol shall be kept on file in the pharmacy and be made available upon request of the board or the authorized provider’s licensing board.

e. An authorized provider may terminate or amend the collaborative drug therapy management protocol with an authorized pharmacist if the authorized provider notifies the authorized pharmacist in writing. Notification shall include the name of the authorized pharmacist, the desired change, and the proposed effective date of the change. Written notification shall be maintained in the pharmacy and be made available upon request of the board or the authorized provider’s licensing board.

f. The authorized provider or pharmacist who initiates a protocol with a patient is responsible for securing the patient’s written consent to participate in drug therapy management and for transmitting a copy of the consent to the other party within 24 hours. The consent shall indicate which protocol is involved. Any variation in the protocol for a specific patient shall be communicated to the other party at the time of securing the patient’s consent. The patient’s authorized provider shall maintain the patient consent in the patient’s medical record.

39.13(3) Hospital practice protocol.

a. A hospital’s P&T committee shall determine the scope and extent of collaborative drug therapy management practices that may be conducted by the hospital’s pharmacists.

b. Collaborative drug therapy management within a hospital setting or the hospital’s clinic setting is valid only when approved by the hospital’s P&T committee.

c. The hospital practice protocol shall include:

(1) The names or groups of pharmacists and providers who are authorized by the P&T committee to participate in collaborative drug therapy management.

(2) A plan for development, training, administration, and quality assurance of the protocol.

(3) A detailed written protocol pursuant to which the hospital pharmacist shall base drug therapy management decisions for patients. The protocol shall authorize one or more of the following:

1. Medication orders and prescription drug orders. The protocol may authorize therapeutic interchange or modification of drug dosages based on symptoms or laboratory or physical findings defined in the protocol. The protocol shall include information specific to the dosage, frequency, duration, and route of administration of the drug authorized by the authorized provider. The protocol
shall not authorize the hospital pharmacist to change a Schedule II drug or to initiate a drug not included in the established protocol.

2. Laboratory tests. The protocol may authorize the hospital pharmacist to obtain or to conduct specific laboratory tests as long as the tests relate directly to the drug therapy management.

3. Physical findings. The protocol may authorize the hospital pharmacist to check certain physical findings, e.g., vital signs, oximetry, or peak flows, that enable the pharmacist to assess and adjust the drug therapy, detect adverse drug reactions, or determine if the patient should be referred back to the authorized provider for follow-up.

4. Circumstances that shall cause the hospital pharmacist to initiate communication with the patient’s authorized provider including but not limited to the need for new medication orders and prescription drug orders and reports of a patient’s therapeutic response or adverse reaction.

5. A statement of the medication categories and the type of initiation and modification of drug therapy that the P&T committee authorizes the hospital pharmacist to perform.

6. A description of the procedures or plan that the hospital pharmacist shall follow if the hospital pharmacist modifies a drug therapy.

7. A description of the mechanism for the hospital pharmacist and the patient’s authorized provider to communicate and for the hospital pharmacist to document implementation of the collaborative drug therapy.

[ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—39.14 and 39.15 Reserved.

657—39.16(155A) Pharmacy pilot or demonstration research projects. The purpose of this rule is to specify the procedures to be followed in applying for approval of a pilot or demonstration research project for innovative applications in the practice of pharmacy as authorized by 2011 Iowa Acts, chapter 63, section 36, as amended by 2012 Iowa Acts, chapter 1113, section 31, and by 2013 Iowa Acts, chapter 138, section 128. In reviewing projects, the board will consider only projects that expand pharmaceutical care services that contribute to positive patient outcomes. The board will not consider any project intended only to provide a competitive advantage to a single applicant or group of applicants.

39.16(1) Definitions. For the purposes of this rule, the following definitions shall apply:

“Ace” means Iowa Code chapter 155A, the Iowa pharmacy practice Act.

“Board” means the Iowa board of pharmacy.

“Practice of pharmacy” means the practice of pharmacy as defined in Iowa Code section 155A.3(34).

“Project” means a pilot or demonstration research project as described in this rule.

39.16(2) Scope of project. A project may not expand the definition of the practice of pharmacy. A project may include therapeutic substitution or substitution of medical devices used in patient care if such substitution is included under a collaborative drug therapy management protocol established pursuant to rule 657—39.13(155A).

39.16(3) Board approval of a project. Board approval of a project may include the grant of an exception to or a waiver of rules adopted under the Act or under any law relating to the authority of prescription verification and the ability of a pharmacist to provide enhanced patient care in the practice of pharmacy. Project approval, including exception to or waiver of board rules, shall initially be for a specified period of time not exceeding 18 months from commencement of the project. The board may approve the extension or renewal of a project following consideration of a petition that clearly identifies the project, that includes a report similar to the final project report described in paragraph 39.16(6)”a,” that describes and explains any proposed changes to the originally approved and implemented project, and that justifies the need for extending or renewing the term of the project.

39.16(4) Applying for approval of a project. A person who wishes the board to consider approval of a project shall submit to the board a petition for approval that contains at least the following information:

a. Responsible pharmacist. Name, address, telephone number, and pharmacist license number of each pharmacist responsible for overseeing the project.
b. **Location of project.** Name, address, and telephone number of each specific location and, if a location is a pharmacy, the pharmacy license number where the proposed project will be conducted.

c. **Project summary.** A detailed summary of the proposed project that includes at least the following information:

   (1) The goals, hypothesis, and objectives of the proposed project.
   (2) A full explanation of the project and how it will be conducted.
   (3) The time frame for the project including the proposed start date and length of study. The time frame may not exceed 18 months from the proposed start date of the project.
   (4) Background information or literature review to support the proposed project.
   (5) The rule or rules to be waived in order to complete the project and a request to waive the rule or rules.
   (6) Procedures to be used during the project to ensure that the public health and safety are not compromised as a result of the waiver.

39.16(5) **Review and approval or denial of a proposed project.**

   a. **Staff review.** Upon receipt of a petition for approval of a project, board staff shall initially review the petition for completeness and appropriateness. If the petition is incomplete or inappropriate for board consideration, board staff shall return the petition to the requestor with a letter explaining the reason the petition is being returned. A petition that has been returned pursuant to this paragraph may be amended or supplemented as necessary and submitted for reconsideration.

   b. **Board review.** Upon review by the board of a petition for approval of a project, the board shall either approve or deny the petition. If the board approves the petition, the approval:

      (1) Shall be specific for the project requested;
      (2) Shall approve the project for a specific time period; and
      (3) May include conditions or qualifications applicable to the project.

   c. **Inspection.** The project site and project documentation shall be available for inspection and review by the board or its representative at any time during the project review and the approval or denial processes and, if a project is approved, throughout the approved term of the project.

   d. **Documentation maintained.** Project documentation shall be maintained and available for inspection, review, and copying by the board or its representative for at least two years following completion or termination of the project.

39.16(6) **Presentation of reports.** The pharmacist responsible for overseeing a project shall be responsible for submitting to the board any reports required as a condition of a project, including the final project report.

   a. **Final project report.** The final project report shall include a written summary of the results of the project and the conclusions drawn from those results. The final project report shall be submitted to the board within three months after completion or termination of the project.

   b. **Board review.** The board shall receive and review any report regarding the progress of a project and the final project report at a regularly scheduled meeting of the board. The report shall be an item on the open session agenda for the meeting.

[ARC 3858C, IAB 6/20/18, effective 7/25/18]


[Filed ARC 3858C (Notice ARC 3509C, IAB 12/20/17), IAB 6/20/18, effective 7/25/18]
[Filed ARC 4270C (Notice ARC 4096C, IAB 10/24/18), IAB 1/30/19, effective 3/6/19]
[Filed Emergency ARC 4387C, IAB 4/10/19, effective 4/5/19]
[Filed Emergency After Notice ARC 4555C (Notice ARC 4450C, IAB 5/22/19), IAB 7/17/19, effective 7/1/19]
[Filed ARC 4583C (Notice ARC 4388C, IAB 4/10/19), IAB 7/31/19, effective 9/4/19]

1 March 6, 2019, effective date of ARC 4270C [amendments to ch 39] delayed 70 days by the Administrative Rules Review Committee at its meeting held February 8, 2019; delay lifted at the meeting held April 5, 2019.
PUBLIC SAFETY DEPARTMENT[661]
Rules transferred from agency number 680 to 661 to conform with the reorganization numbering scheme in general

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661—278.1(272C) Definitions. The following definitions apply to this chapter.
“Department” means the department of public safety.
“Division” means the state fire marshal division of the department of public safety.
“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.
“Military service applicant” means an individual requesting credit toward licensure for military education, training, or service obtained or completed in military service.
“Veteran” means an individual who meets the definition of “veteran” in Iowa Code section 35.1(2).

[ARC 4584C, IAB 7/31/19, effective 9/4/19]

661—278.2(272C) Military education, training, and service credit. A military service applicant may apply for credit for verified military education, training, or service, toward any experience or educational requirement for licensure, by submitting a military service application form to the division.

278.2(1) The military service application may be submitted with an application for licensure, or prior to applying for licensure. No fee is required for the submission of an application for military service credit.

278.2(2) The military service applicant shall identify the experience or educational licensure requirement for which the credit would be applied, if granted.

278.2(3) The military service applicant shall provide military transcripts, a certified affidavit, or documents that verify completion of the relevant military education, training, or service. These documents may include the military service applicant’s Certificate of Release or Discharge from Active Duty (DD Form 214) or Verification of Military Experience and Training (VMET) (DD Form 2586).

278.2(4) Upon receipt of a completed military service application, the division shall promptly determine whether the verified military education, training, or service will satisfy all or part of the identified experience or educational qualifications for licensure.

278.2(5) The division shall grant credit for the military service application, in whole or in part, if the division determines that the verified military education, training, or service satisfies all or part of the experience or educational qualifications for licensure.

278.2(6) The division shall inform the military service applicant in writing of the credit, if any, given toward an experience or educational qualification for licensure, or explain why no credit was granted. The military service applicant may request reconsideration.

278.2(7) A military service applicant who is aggrieved by the division’s decision may request a contested case (administrative hearing) and may participate in the contested case by telephone. A request for a contested case shall be made within 30 days of the issuance of the division’s decision. There are no fees or costs assessed against the military service applicant in connection with a contested case conducted pursuant to this subrule.

278.2(8) The division shall grant or deny the military service application prior to ruling on the application for licensure. The military service applicant shall not be required to submit any fees in connection with the licensure application unless the division grants the military service application. If the division does not grant the military service application, the military service applicant may withdraw the licensure application or request that the licensure application be placed in pending status for up to one year, unless otherwise mutually agreed upon. The withdrawal of a licensure application shall not preclude subsequent military service applications or licensure applications, supported by additional documentation or information.

[ARC 4584C, IAB 7/31/19, effective 9/4/19]

661—278.3(272C) Veteran reciprocity.
278.3(1) A veteran with a fire protection or alarm system license in another jurisdiction may apply for licensure in Iowa through reciprocity, based on the reciprocity procedures for fire protection and alarm systems licensees as set out in the administrative rules in effect at the time that the military service application is made, and in compliance with any agreements with other jurisdictions regarding reciprocity. A fully completed licensure application submitted by a veteran under this subrule is to be given priority and is expedited.

278.3(2) A licensure application shall contain all of the information required of all military service applicants for licensure who hold unrestricted licenses in other jurisdictions and who are applying for licensure by reciprocity. This information includes, but is not limited to, completion of all required forms, payment of applicable fees, disclosure of criminal or disciplinary history and, if applicable, a criminal history background check. In addition, the veteran shall provide such documentation as is reasonably needed to verify the veteran’s status as a veteran under Iowa Code section 35.1(2).

278.3(3) Upon receipt of a fully completed licensure application, the division shall promptly determine if the licensing requirements of the jurisdiction where the veteran is licensed are substantially equivalent to the licensing requirements in Iowa. The division shall make this determination based on information supplied by the veteran and additional information the division may acquire from the applicable jurisdiction. The division may consider the following factors in determining substantial equivalence: scope of practice, education and coursework, degree requirements, and postgraduate experiences.

278.3(4) The division shall promptly grant a license to the veteran if the veteran is licensed in the same or similar profession in another jurisdiction whose licensure requirements are substantially equivalent to the licensing requirements in Iowa, unless the veteran is ineligible for licensure based on other grounds, such as the veteran’s disciplinary or criminal history.

278.3(5) If the division determines that the licensing requirements of the jurisdiction in which the veteran is licensed are not substantially equivalent to the licensing requirements in Iowa, the division shall promptly inform the veteran of the additional experience, education, or examinations required for licensure in Iowa. Unless the veteran is ineligible for licensure based on other grounds, such as disciplinary or criminal history, the following shall apply:

a. If a veteran has not obtained the required certification for licensure, the veteran may not be issued a provisional license but may request that the licensure application be placed in pending status for up to one year, or as mutually agreed upon, to provide the veteran with the opportunity to satisfy the certification requirements.

b. If additional experience or education is required for the veteran’s qualifications to be considered substantially equivalent, the veteran may request that the division issue a provisional license for a specified period of time, during which the veteran will successfully complete the necessary experience or education. The division shall issue a provisional license for a specified period of time upon such conditions as the division deems reasonably necessary to protect the health, welfare, or safety of the public unless the division determines that the deficiency is of a character that the public health, welfare, or safety will be adversely affected if a provisional license is granted.

c. If a request for a provisional license is denied, the division shall notify the veteran in writing, explaining the decision, and shall inform the veteran of the steps the veteran may take in order to receive a provisional license.

d. If a provisional license is issued, the application for full licensure is placed in pending status until the necessary experience or education has been successfully completed or the provisional license expires, whichever comes first. The division may extend a provisional license on a case-by-case basis for good cause.

278.3(6) A veteran who is aggrieved by the division’s decision to deny an application for a reciprocal license or a provisional license or is aggrieved by the terms under which a provisional license will be granted may request a contested case (administrative hearing) and may participate in the contested case by telephone. A request for a contested case shall be made within 30 days of the issuance of the division’s
decision. There are no fees or costs assessed against the veteran in connection with a contested case conducted pursuant to this subrule.

[ARC 4584C, IAB 7/31/19, effective 9/4/19]

These rules are intended to implement Iowa Code section 272C.4.

[Filed ARC 4584C (Notice ARC 4475C, IAB 6/5/19), IAB 7/31/19, effective 9/4/19]
CHAPTERS 279 to 290
Reserved
701—68.1(452A) Definitions. See 701—67.1(452A).

701—68.2(452A) Tax rates—time tax attaches—responsible party.

68.2(1) The following rates of tax apply to the use of fuel in operating motor vehicles and aircraft:

<table>
<thead>
<tr>
<th>Fuel Type</th>
<th>Rate per Gallon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gasoline</td>
<td>20.3¢ per gallon for 2003, through June 30, 2004</td>
</tr>
<tr>
<td></td>
<td>20.5¢ per gallon for 2004, through June 30, 2005</td>
</tr>
<tr>
<td></td>
<td>20.7¢ per gallon for 2005, through June 30, 2006</td>
</tr>
<tr>
<td></td>
<td>21¢ per gallon for 2006, through June 30, 2007</td>
</tr>
<tr>
<td></td>
<td>20.7¢ per gallon for 2007, through June 30, 2008</td>
</tr>
<tr>
<td></td>
<td>21¢ per gallon for 2008, through February 28, 2015</td>
</tr>
<tr>
<td></td>
<td>31¢ per gallon for 2015, through June 30, 2015</td>
</tr>
<tr>
<td></td>
<td>30.8¢ per gallon for 2015, through June 30, 2016</td>
</tr>
<tr>
<td></td>
<td>30.7¢ per gallon for 2016, through June 30, 2017</td>
</tr>
<tr>
<td></td>
<td>30.5¢ per gallon for 2017, through June 30, 2018</td>
</tr>
<tr>
<td></td>
<td>30.7¢ per gallon for 2018, through June 30, 2019</td>
</tr>
<tr>
<td></td>
<td>30.5¢ per gallon (beginning July 1, 2019)</td>
</tr>
<tr>
<td>Ethanol blended gasoline</td>
<td>19¢ per gallon (2003, through February 28, 2015)</td>
</tr>
<tr>
<td></td>
<td>29¢ per gallon (2015, through March 1, 2015)</td>
</tr>
<tr>
<td></td>
<td>29.3¢ per gallon (2015, through June 30, 2016)</td>
</tr>
<tr>
<td></td>
<td>29¢ per gallon (beginning July 1, 2016)</td>
</tr>
<tr>
<td>E-85 gasoline</td>
<td>17¢ per gallon (January 1, 2006, through June 30, 2007)</td>
</tr>
<tr>
<td></td>
<td>19¢ per gallon (2007, through February 28, 2015)</td>
</tr>
<tr>
<td></td>
<td>29¢ per gallon (2015, through March 1, 2015)</td>
</tr>
<tr>
<td></td>
<td>29.3¢ per gallon (2015, through June 30, 2016)</td>
</tr>
<tr>
<td></td>
<td>29¢ per gallon (beginning July 1, 2016)</td>
</tr>
<tr>
<td>Aviation gasoline</td>
<td>8¢ per gallon (beginning July 1, 1988)</td>
</tr>
<tr>
<td>Diesel fuel other than B-11 or higher</td>
<td>22.5¢ per gallon (on and before February 28, 2015)</td>
</tr>
<tr>
<td></td>
<td>32.5¢ per gallon (beginning March 1, 2015)</td>
</tr>
<tr>
<td>Biodiesel blended fuel (B-11 or higher)</td>
<td>22.5¢ per gallon (on and before February 28, 2015)</td>
</tr>
<tr>
<td></td>
<td>32.5¢ per gallon (2015, through March 1, 2015)</td>
</tr>
<tr>
<td></td>
<td>29.5¢ per gallon (beginning July 1, 2015)</td>
</tr>
<tr>
<td>Aviation jet fuel</td>
<td>3¢ per gallon (on and before February 28, 2015)</td>
</tr>
<tr>
<td></td>
<td>5¢ per gallon (beginning March 1, 2015)</td>
</tr>
<tr>
<td>L.P.G.</td>
<td>20¢ per gallon (on and before February 28, 2015)</td>
</tr>
<tr>
<td></td>
<td>30¢ per gallon (beginning March 1, 2015)</td>
</tr>
<tr>
<td>C.N.G.</td>
<td>16¢ per 100 cu. ft. (on and before June 30, 2014)</td>
</tr>
<tr>
<td></td>
<td>21¢ per gallon (2014, through February 28, 2015)</td>
</tr>
<tr>
<td></td>
<td>31¢ per gallon (beginning March 1, 2015)</td>
</tr>
<tr>
<td>L.N.G.</td>
<td>22.5¢ per gallon (on and before February 28, 2015)</td>
</tr>
<tr>
<td></td>
<td>32.5¢ per gallon (beginning March 1, 2015)</td>
</tr>
</tbody>
</table>

68.2(2) Fuel distribution percentages.
   a. Ethanol distribution percentage.
      (1) Except as otherwise provided in this paragraph, for March 1, 2015, through June 30, 2020, this paragraph shall apply to the excise tax imposed on each gallon of motor fuel used for any purpose for the privilege of operating motor vehicles in this state. The rate of the excise tax shall be based on the ethanol distribution percentage. The ethanol distribution percentage is the number of gallons of ethanol blended gasoline that is distributed in this state as expressed as a percentage of the number of gallons of motor fuel,
excluding aviation gasoline, distributed in this state. The number of gallons of ethanol blended gasoline and motor fuel distributed in this state shall be based on the total taxable gallons of ethanol blended gasoline and motor fuel as shown on the fuel tax monthly reports issued by the department for January through December for each determination period. The department shall determine the percentage for each determination period beginning January 1 and ending December 31. The rate for the excise tax shall apply for the period beginning July 1 and ending June 30 following the end of the determination period. The rate for the excise tax shall be as follows:

<table>
<thead>
<tr>
<th>Ethanol Distribution %</th>
<th>Ethanol Tax</th>
<th>Gasoline Tax</th>
</tr>
</thead>
<tbody>
<tr>
<td>00/50</td>
<td>29.0</td>
<td>30.0</td>
</tr>
<tr>
<td>50+/55</td>
<td>29.0</td>
<td>30.1</td>
</tr>
<tr>
<td>55+/60</td>
<td>29.0</td>
<td>30.3</td>
</tr>
<tr>
<td>60+/65</td>
<td>29.0</td>
<td>30.5</td>
</tr>
<tr>
<td>65+/70</td>
<td>29.0</td>
<td>30.7</td>
</tr>
<tr>
<td>70+/75</td>
<td>29.0</td>
<td>31.0</td>
</tr>
<tr>
<td>75+/80</td>
<td>29.3</td>
<td>30.8</td>
</tr>
<tr>
<td>80+/85</td>
<td>29.5</td>
<td>30.7</td>
</tr>
<tr>
<td>85+/90</td>
<td>29.7</td>
<td>30.4</td>
</tr>
<tr>
<td>90+/95</td>
<td>29.9</td>
<td>30.1</td>
</tr>
<tr>
<td>95+/100</td>
<td>30.0</td>
<td>30.0</td>
</tr>
</tbody>
</table>

(2) Except as otherwise provided in this paragraph, after June 30, 2020, an excise tax of 30 cents is imposed on each gallon of motor fuel used for any purpose for the privilege of operating motor vehicles in this state.

b. Biodiesel distribution percentage.

(1) Except as otherwise provided in this paragraph, for July 1, 2015, through June 30, 2020, this paragraph shall apply to the excise tax imposed on each gallon of special fuel for diesel engines of motor vehicles used for any purpose for the privilege of operating motor vehicles in this state. The rate of the excise tax shall be based on the biodiesel distribution percentage. The biodiesel distribution percentage is the number of gallons of biodiesel blended fuel classified as B-11 or higher that is distributed in this state as expressed as a percentage of the number of gallons of special fuel for diesel engines of motor vehicles distributed in this state. The number of gallons of biodiesel blended fuel and special fuel for diesel engines of motor vehicles distributed in this state shall be based on the total taxable gallons of biodiesel blended fuel and special fuel for diesel engines of motor vehicles as shown on the fuel tax monthly reports issued by the department for January through December for each determination period. The department shall determine the percentage for each determination period beginning January 1 and ending December 31. The rate for the excise tax shall apply for the period beginning July 1 and ending June 30 following the end of the determination period. The rate for the excise tax shall be as follows:
(2) The determination period for the biodiesel distribution percentage is January through December each calendar year. Prior to July 1, 2015, Iowa licensees did not separately report the total taxable gallons of biodiesel blended fuel classified as B-11 or higher that is distributed in this state. Accordingly, the department cannot calculate the biodiesel distribution percentage for calendar years 2014 and 2015 using the method described in subparagraph 68.2(2)”b”(1). However, the best information available to the department indicates the biodiesel distribution percentage is not greater than 50 percent for calendar years 2014 and 2015. Therefore, for the period between July 1, 2015, and June 30, 2016, and for the period between July 1, 2016, and June 30, 2017, the rates for the excise tax on special fuel for diesel engines of motor vehicles are based on a biodiesel distribution percentage of 00/50%.

(3) Except as otherwise provided in this paragraph, for the period between March 1, 2015, and June 30, 2015, and for the period after June 30, 2020, an excise tax of 32.5 cents is imposed on each gallon of special fuel for diesel engines of motor vehicles used for any purpose for the privilege of operating motor vehicles in this state.

c. Legislative review: The ethanol distribution percentage, the biodiesel distribution percentage, and the corresponding excise tax rates are subject to legislative review at least every six years. The review is based upon a fuel distribution percentage formula status report, which contains the recommendations of a legislative interim committee appointed to conduct a review of the fuel distribution percentage formulas. The report is prepared with the assistance of the Iowa department of revenue and the Iowa department of transportation. The report includes recommendations for changes or revisions to the fuel distribution percentage formulas based upon advances in technology, fuel use trends, and fuel price fluctuations observed during the preceding six-year interval; an analysis of the operation of the fuel distribution percentage formulas during the preceding six-year interval; and a summary of issues that have arisen since the previous review and potential approaches for resolution of those issues. The first report will be submitted to the general assembly no later than January 1, 2020, with subsequent reports developed and submitted by January 1 at least every sixth year thereafter.

68.2(3) The tax attaches when the fuel is withdrawn from a terminal or imported into Iowa. The tax is payable to the department by the supplier, restrictive supplier, importer, blender, or any person who owns the fuel at the time it is brought into the state by a restrictive supplier or importer or any other person who possesses taxable fuel upon which the tax has not been paid. The tax is to be remitted to the department by a supplier, restrictive supplier, or blender by the last day of the month following the month in which the fuel is withdrawn from a terminal or imported. The tax is to be remitted by an importer by the last day of the month for fuel imported in the first 15 days of the month and by the fifteenth day of the following month for fuel imported after the fifteenth day of the previous month. Nonlicensees who possess taxable fuel upon which the tax has not been paid must file returns and pay the tax the same as a restrictive supplier (monthly). All licensees must make payment by electronic funds transfer (see publication 90-201 for EFT requirements).

<table>
<thead>
<tr>
<th>Biodiesel Distribution %</th>
<th>B-11 or Higher Tax</th>
<th>Other Than B-11 or Higher Tax</th>
</tr>
</thead>
<tbody>
<tr>
<td>00/50</td>
<td>29.5</td>
<td>32.5</td>
</tr>
<tr>
<td>50+/55</td>
<td>29.8</td>
<td>32.5</td>
</tr>
<tr>
<td>55+/60</td>
<td>30.1</td>
<td>32.5</td>
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</tr>
<tr>
<td>65+/70</td>
<td>30.7</td>
<td>32.5</td>
</tr>
<tr>
<td>70+/75</td>
<td>31.0</td>
<td>32.5</td>
</tr>
<tr>
<td>75+/80</td>
<td>31.3</td>
<td>32.5</td>
</tr>
<tr>
<td>80+/85</td>
<td>31.6</td>
<td>32.5</td>
</tr>
<tr>
<td>85+/90</td>
<td>31.9</td>
<td>32.5</td>
</tr>
<tr>
<td>90+/95</td>
<td>32.2</td>
<td>32.5</td>
</tr>
<tr>
<td>95+/100</td>
<td>32.5</td>
<td>32.5</td>
</tr>
</tbody>
</table>
68.2(4) The department shall determine the actual tax paid for E-85 gasoline in the previous calendar year and compare this amount to the amount that would have been paid using the tax rate imposed in Iowa Code section 452A.3, subsection 1 or 2. If the difference is less than $25,000, the tax rate for the tax period beginning the following July 1 shall be 17¢ per gallon. If the difference is $25,000 or more, the tax rate shall be the rate in effect pursuant to Iowa Code section 452A.3, subsection 1 or 2.

Beginning January 1, 2006, retailers of E-85 gasoline must file a report with the department by the last day of the month of each calendar quarter for each retail location showing the number of invoiced gallons of E-85 gasoline sold by the retailer in Iowa during the preceding calendar quarter. The report must also include a listing of the vendors providing E-85 gasoline to the retailer and the number of gallons received from each vendor. If the retailer blends E-85 gasoline, the retailer must show the number of gallons of motor fuel (including both gasoline and alcohol) purchased and blended. The report must be signed under penalty for false certificate.

68.2(5) Persons having title to motor fuel, ethanol blended gasoline, undyed special fuel, compressed natural gas, liquefied natural gas, or liquefied petroleum gas shall be subject to an inventory tax based upon the gallonage in storage as of the close of the business day preceding the effective date of the increased excise tax rate of motor fuel, ethanol blended gasoline, undyed special fuel, compressed natural gas, liquefied natural gas, or liquefied petroleum gas which will be subject to the increased excise tax rate.

Persons subject to the tax imposed under this subrule shall take an inventory to determine the gallonage in storage for purposes of determining the tax and shall report the gallonage and pay the tax due within 30 days of the prescribed inventory date. The amount of the inventory tax is equal to the inventory tax rate times the gallonage in storage. The inventory tax rate is equal to the increased excise tax rate less the previous excise tax rate. The inventory tax does not apply to an increase in the tax rate of a specified fuel, except for compressed natural gas, unless the increase in the tax rate of that fuel is in excess of one-half cent per gallon.

This rule is intended to implement Iowa Code sections 452A.3, 452A.8 and 452A.85. [ARC 8225B, IAB 10/7/09, effective 11/11/09; ARC 0399C, IAB 10/17/12, effective 11/21/12; ARC 1442C, IAB 4/30/14, effective 6/4/14; ARC 1805C, IAB 1/7/15, effective 2/11/15; ARC 2247C, IAB 11/25/15, effective 12/30/15; ARC 2698C, IAB 8/31/16, effective 10/5/16; ARC 3146C, IAB 6/21/17, effective 7/26/17; ARC 4252C, IAB 1/16/19, effective 2/20/19; ARC 4585C, IAB 7/31/19, effective 9/4/19]

701—68.3(452A) Exemption. Motor fuel or undyed special fuel sold for export or exported from this state to another state, territory, or foreign country is exempt from the excise tax. The fuel is deemed sold for export or exported only if the bill of lading or manifest indicates that the destination of the fuel withdrawn from the terminal is outside the state of Iowa. The mode of transportation is not of consequence. In the event fuel is taxed and then subsequently exported, an amount equal to the tax previously paid will be allowable as a refund, upon receipt by the department of the appropriate documents, to the party who originally paid the tax. If the sale of exported fuel is completed in Iowa, then the sale is subject to Iowa sales tax if it is not exported for resale otherwise exempt from sales tax. The sale is completed in Iowa if the foreign purchaser takes physical possession of the fuel in this state. Dedgen Industries, Inc. v. Iowa State Tax Commission, 160 N.W.2d 289 (Iowa 1968). See sales tax rule 701—18.37(422,423).

Indelible dye meeting United States Environmental Protection Agency and Internal Revenue Service regulations must be added to fuel before or upon withdrawal at a terminal or refinery rack for that fuel to be exempt from tax and the dyed fuel can only be used for a nontaxable purpose listed in Iowa Code section 452A.17, subsection 1, paragraph "a." However, this exemption does not apply to fuel used for idle time, power takeoffs, reefer units, or pumping credits, or fuel used by contract carriers.

This rule is intended to implement Iowa Code section 452A.3 as amended by 1995 Iowa Acts, chapter 155.

701—68.4(452A) Blended fuel taxation—nonterminal location.
68.4(1) Responsibilities of all blenders at nonterminal locations. A person who blends ethanol blended gasoline or biodiesel blended fuel at a nonterminal location must obtain a blender’s license. Blending ethanol with gasoline, or blending biodiesel with petrodiesel, may result in additional tax due or an allowable refund depending on the alcohol content of the mixture and the tax paid on its components. The blender must make payment to the department for the additional tax due. The blender must obtain a refund permit to receive a refund of the overpayment of tax on the blended product.

Example 1. A blender blends three parts ethanol with 17 parts gasoline to create E-15. The E-15 is taxed as ethanol blended gasoline, and the blender may be due a refund for excess tax paid on the gasoline used.

Example 2. A blender blends one part biodiesel with four parts petrodiesel to create B-20. The B-20 is taxed as B-11 or higher, and the blender may be due a refund for excess tax paid on the petrodiesel used.

Example 3. A blender blends one part biodiesel with 19 parts petrodiesel to create B-5. The B-5 is taxed as diesel other than B-11 or higher, and the blender may owe additional tax to the department on the biodiesel used.

Example 4. A blender blends one part B-20 with five parts B-2 to create B-5. The B-5 is taxed as diesel other than B-11 or higher, and the blender may owe additional tax to the department on the B-20 used.

68.4(2) Blenders of ethanol blended gasoline.

a. A blender who owns the alcohol (supplier) being used to blend with gasoline must purchase the gasoline from a supplier and pay the appropriate tax to the supplier. The blender must obtain a blender’s license and compute the tax due on the total gallons of blended product and make payment to the department for the additional amount due. For purposes of the following example, the tax rate for gasoline is presumed to be 30¢ per gallon and the tax rate for ethanol blended gasoline is presumed to be 29¢ per gallon. The actual tax rates for the appropriate period are shown in subrule 68.2(1).

Example:

Blender purchases 7,200 gallons tax-paid gasoline (7,200 × .30) = $2,160.00
Blender adds 800 gallons untaxed alcohol $ .00
Total tax paid on products $2,160.00
Total tax due on 8,000 gallons ethanol blended gasoline (8,000 × .29) = $2,320.00
Additional Amount Due $160.00

b. A blender who purchases alcohol and gasoline from a supplier must pay tax on both the alcohol purchased and the gasoline purchased. The blender must obtain a refund permit to receive a refund of the overpayment of tax on the blended product. For purposes of the following example, the tax rate for gasoline is presumed to be 30¢ per gallon and the tax rate for ethanol blended gasoline is presumed to be 29¢ per gallon. The actual tax rates for the appropriate period are shown in subrule 68.2(1).

Example:

Blender purchases 7,200 gallons tax-paid gasoline (7,200 × .30) = $2,160.00
Blender purchases 800 gallons tax-paid alcohol (800 × .29) = $232.00
Total tax paid on products $2,392.00
Total tax due on 8,000 gallons ethanol blended gasoline (8,000 × .29) = $2,320.00
Amount of Refund Allowable $72.00

c. Ethanol blended gasoline—blending errors.
Where a blending error occurs and an insufficient amount of alcohol has been blended with gasoline so that the mixture fails to qualify as ethanol blended gasoline as defined in Iowa Code section 452A.2, a 1 percent tolerance applies in determining the tax on the blended product as described in this paragraph:

1. If the amount of the alcohol erroneously blended with gasoline is at least 9 percent of the total blended product by volume, the alcohol and gasoline blended product is considered ethanol blended gasoline and there is no penalty or assessment of additional tax.

2. If the amount of alcohol erroneously blended with gasoline is less than 9 percent of the total blended product by volume, the total blend of gasoline and alcohol is subject to tax as gasoline at the prevailing rate of tax.

3. This paragraph applies only if a blender intends to produce ethanol blended gasoline. If a blender does not intend to produce ethanol blended gasoline when blending alcohol and gasoline, and the mixture contains less than 10 percent alcohol by volume, no error has occurred and the mixture is subject to tax as gasoline.

4. The following formulas are used to compute blending errors:
   - Actual gasoline + actual alcohol = total gallons of blended product
   - Total gallons of blended product × .09 = required alcohol

5. Examples. The following factors are assumed for all examples:
   - The blender in each example intends to blend ethanol blended gasoline. Figures are rounded to the nearest whole gallon; ethanol blended gasoline is taxed at $.29 per gallon; gasoline is taxed at $.30 per gallon. The actual tax rates for the appropriate period are shown in subrule 68.2(1). Penalty and interest charges are not computed in the examples.

**Example 1:**
Actual gasoline = 8,000 gal.
Actual alcohol = 800 gal.
Total blended product = 8,800 gal.
8,800 × .09 = 792 gal. required alcohol

The actual alcohol (800 gallons) is more than the required alcohol (792 gallons), which means that the tax is applied according to subparagraph 68.4(2) “c”(1) as follows:

- 8,800 gal. of blended product × $.29 = $2,552 tax on ethanol blended gasoline

**Example 2:**
Actual gasoline = 8,010 gal.
Actual alcohol = 790 gal.
Total blended product = 8,800 gal.
8,800 × .09 = 792 gal. required alcohol

The actual alcohol (790 gallons) is less than the required alcohol (792 gallons), which means that the entire blend is considered gasoline and the tax is applied according to subparagraph 68.4(2) “c”(2) as follows:

- 8,800 gal. of blended product × $.30 = $2,640 tax on gasoline

**68.4(3) Blenders of biodiesel blended fuel.**

a. A blender who owns the biodiesel (supplier) being used to blend with diesel must purchase the diesel from a supplier and pay the appropriate tax to the supplier. The blender must obtain a blender’s
license and compute the tax due on the total gallons of blended product and make payment to the department for the additional amount due. For purposes of the following examples, the tax rate for B-11 or higher is presumed to be 29¢ per gallon and the tax rate for diesel other than B-11 or higher is presumed to be 32.5¢ per gallon. The actual tax rates for the appropriate period are shown in subrule 68.2(1).

**Example 1.**
Blender purchases 7,120 gallons tax-paid petrodiesel (7,120 × .325) = $2,314.00
Blender adds 880 gallons untaxed biodiesel = $.00
Total tax paid on products = $2,314.00

The blended product is 8,000 gallons of diesel, which includes 880 gallons (11% by volume) of biodiesel. Thus, the product is taxed as B-11 or higher.

Total tax due on 8,000 gallons blended B-11 or higher (8,000 × .29) = $2,320.00
Additional Amount Due = $6.00

**Example 2.**
Blender purchases 7,600 gallons tax-paid petrodiesel (7,600 × .325) = $2,470.00
Blender adds 400 gallons untaxed biodiesel = $.00
Total tax paid on products = $2,470.00

The blended product is 8,000 gallons of diesel, which includes 400 gallons (5% by volume) of biodiesel. Thus, the product is taxed as diesel other than B-11 or higher.

Total tax due on 8,000 gallons diesel other than B-11 or higher (8,000 × .325) = $2,600.00
Additional Amount Due = $130.00

**Example 3.**
Blender purchases 7,750 gallons tax-paid B-2 (7,750 × .325) = $2,518.75
Blender adds 250 gallons untaxed biodiesel = $.00
Total tax paid on products = $2,518.75

7,750 gallons of B-2 contains 155 gallons (2%) of biodiesel. The blended product is 8,000 gallons of diesel, which includes 405 gallons (155 + 250, or 5% by volume) of biodiesel. Thus, the product is taxed as diesel other than B-11 or higher.

Total tax due on 8,000 gallons diesel other than B-11 or higher (8,000 × .325) = $2,600.00
Additional Amount Due = $81.25

b. A blender who purchases diesel products from a supplier must pay the appropriate tax on all diesel products purchased. The blender must obtain a blender’s license and compute the tax due on the total gallons of blended product and make payment to the department for any additional amount due. The blender must also obtain a refund permit to receive a refund of any overpayment of tax on the blended product. For purposes of the following examples, the tax rate for B-11 or higher is presumed to be 29¢ per gallon and the tax rate for diesel fuel other than B-11 or higher is presumed to be 32.5¢ per gallon. The actual tax rates for the appropriate period are shown in subrule 68.2(1).
EXAMPLE 1.

Blender purchases 7,120 gallons tax-paid petrodiesel (7,120 \times 0.325) = $2,314.00
Blender purchases 880 gallons tax-paid biodiesel (880 \times 0.29) = $255.20
Total tax paid on products = $2,569.20

The blended product is 8,000 gallons of diesel, which includes 880 gallons (11% by volume) of biodiesel. Thus, the product is taxed as B-11 or higher.

Total tax due on 8,000 gallons blended B-11 or higher (8,000 \times 0.29) = $2,320.00
Amount of Refund Allowable = $249.20

EXAMPLE 2.

Blender purchases 7,600 gallons tax-paid petrodiesel (7,600 \times 0.325) = $2,470.00
Blender purchases 400 gallons tax-paid biodiesel (400 \times 0.29) = $116.00
Total tax paid on products = $2,586.00

The blended product is 8,000 gallons of biodiesel blended fuel, which includes 400 gallons (5% by volume) of biodiesel. Thus, the product is taxed as diesel other than B-11 or higher.

Total tax due on 8,000 gallons blended B-5 (8,000 \times 0.325) = $2,600.00
Additional Amount Due = $14.00

EXAMPLE 3.

Blender purchases 4,000 gallons tax-paid B-2 (4,000 \times 0.325) = $1,300.00
Blender purchases 4,000 gallons tax-paid B-20 (4,000 \times 0.29) = $1,160.00
Total tax paid on products = $2,460.00

4,000 gallons of B-2 contains 80 gallons (2%) of biodiesel, and 4,000 gallons of B-20 contains 800 gallons (20%) of biodiesel. The blended product is 8,000 gallons of diesel, which includes 880 gallons (80 + 800, or 11% by volume) of biodiesel. Thus, the product is taxed as B-11 or higher.

Total tax due on 8,000 gallons B-11 or higher (8,000 \times 0.29) = $2,320.00
Amount of Refund Allowable = $140.00

c. Blending errors. Where a blending error occurs and an insufficient amount of biodiesel has been blended with petrodiesel so that the mixture fails to qualify as B-11 or higher as defined in rule 701—67.1(452A), a 1 percent tolerance applies in determining the tax on the blended product as described in this paragraph:

(1) If the amount of the biodiesel erroneously blended with petrodiesel is at least 10 percent of the total blended product by volume, the biodiesel and petrodiesel blended product is considered B-11 or higher and there is no penalty or assessment of additional tax.

(2) If the amount of biodiesel blended with petrodiesel is less than 10 percent of the total blended product by volume, the entire mixture is considered taxable diesel other than B-11 or higher and subject to tax at the prevailing rate.

(3) This paragraph applies only if a blender intends to produce B-11 or higher. If a blender does not intend to produce B-11 or higher when blending biodiesel and petrodiesel, and the mixture contains less than 11 percent biodiesel by volume, no error has occurred and the mixture is subject to tax as diesel other than B-11 or higher.

(4) The following formulas are used to compute blending errors:
Actual biodiesel + actual petrodiesel = total gallons of blended product
Total gallons of blended product × .1 = required biodiesel

(5) Examples. The following factors are assumed for all examples:
The blender in each example intends to blend B-11 or higher. Figures are rounded to the nearest whole gallon; B-11 or higher is taxed at $0.29 per gallon; diesel other than B-11 or higher is taxed at $0.325 per gallon. The actual tax rates for the appropriate period are shown in subrule 68.2(1). Penalty and interest charges are not computed in the examples.

**Example 1.**
Actual petrodiesel = 8,095 gal.
Actual biodiesel = 905 gal.
Total blended product = 9,000 gal.
9,000 × .1 = 900 gal. required biodiesel

The actual biodiesel (905 gallons) is more than the required biodiesel (900 gallons). Thus, the tax is applied according to subparagraph 68.4(3)’c’(1) as follows:
9,000 gal. of blended product × $0.29 = $2,610 tax on B-11 or higher

**Example 2.**
Actual petrodiesel = 8,105 gal.
Actual biodiesel = 895 gal.
Total blended product = 9,000 gal.
9,000 × .1 = 900 gal. required biodiesel

The actual biodiesel (895 gallons) is less than the required biodiesel (900 gallons). Thus, the tax is applied according to subparagraph 68.4(3)’c’(2) as follows:
9,000 gal. of blended product × $0.325 = $2,925 tax on diesel other than B-11 or higher

**Example 3.**
A blender erroneously mixes 5,000 gallons of B-2 with 4,500 gallons of B-20 with the intent of creating B-11 or higher. 5,000 gallons of B-2 contains 100 gallons (2%) of biodiesel. 4,500 gallons of B-20 contains 900 gallons (20%) of biodiesel. Thus, the 9,500 gallons (4,500 + 5,000) of blended product includes 1,000 gallons (100 + 900) of biodiesel and 8,500 gallons (9,500 – 1,000) of petrodiesel.
Actual petrodiesel = 8,500 gal.
Actual biodiesel = 1,000 gal.
Total blended product = 9,500 gal.
9,500 × .1 = 950 gal. required biodiesel

The actual biodiesel (1,000 gallons) is greater than the required biodiesel (950 gallons), which means that the entire blend is considered B-11 or higher and the tax is applied according to subparagraph 68.4(3)’c’(1) as follows:
9,500 gal. of blended product = $2,755 tax on B-11 or higher
× $.29

This rule is intended to implement Iowa Code section 452A.8 as amended by 2015 Iowa Acts, Senate File 257.
[ARC 2247C, IAB 11/25/15, effective 12/30/15]

701—68.5(452A) Tax returns—computations.

68.5(1) Supplier—nexus.

a. The fuel tax liability for a supplier is computed by multiplying the per gallon fuel tax rate by the total number of invoiced gallons of motor fuel or undyed special fuel withdrawn from the terminal by the supplier within the state or by the supplier with an Iowa nexus from a terminal outside the state during the preceding calendar month, less deductions for fuel exported in the case of in-state withdrawals and the distribution allowance provided for in Iowa Code section 452A.5.

Tax shall not be paid when the sale of alcohol occurs within a terminal from an alcohol manufacturer to a licensed supplier. The tax shall be paid by the licensed supplier when the invoiced gross gallonage of the alcohol or the alcohol part of the ethanol blended gasoline is withdrawn from a terminal for delivery in this state. This makes the licensed supplier responsible for the tax on both the alcohol and the gasoline portions of the ethanol blended gasoline and for the reporting and accounting of this fuel as ethanol blended gasoline on the supplier report.

b. If fuel is withdrawn by a supplier with no nexus in Iowa, but who voluntarily agrees to collect and report the tax, from a terminal outside of Iowa for importation into Iowa, the tax liability is computed in the same manner as in paragraph “a” with the exception that no deduction is allowable for exports.

68.5(2) The fuel tax liability for a restrictive supplier is to be computed by multiplying the per gallon fuel tax rate by the total number of invoiced gallons of motor fuel or undyed special fuel imported into Iowa during the preceding calendar month.

68.5(3) The fuel tax liability for an importer is computed by multiplying the per gallon fuel tax rate by the total number of invoiced gallons of motor fuel or undyed special fuel imported into Iowa during the applicable reporting period.

68.5(4) The tax liability for a nonlicensee is computed the same as a restrictive supplier. If motor fuel or undyed special fuel is exported from this state with no tax paid and subsequently returned to this state because all or a portion of it was not delivered where destined, the tax must be paid to the department by the nonlicensee.

All entries on the return for determining the tax liability must be rounded to the nearest whole number.

This rule is intended to implement Iowa Code section 452A.3 as amended by 2001 Iowa Acts, House File 736, and sections 452A.5, 452A.8, and 452A.9.

701—68.6(452A) Distribution allowance. The tax computation for a supplier includes a distribution allowance of 1.6 percent of the motor fuel gallonage and 0.7 percent of the undyed special fuel gallonage removed from the terminal during the reporting period. The distributor purchasing the fuel from the supplier is entitled to 1.2 percent of the motor fuel distribution allowance. The distributor or dealer purchasing fuel from a supplier is entitled to 0.35 percent of the undyed special fuel distribution allowance. The distribution allowance does not apply to fuel exported.

This rule is intended to implement Iowa Code sections 452A.5 and 452A.8 as amended by 1995 Iowa Acts, chapter 155.

701—68.7(452A) Supplier credit—uncollectible account. A licensed supplier who is unable to recover the tax from an eligible purchaser or end user is not liable for the tax and may credit the amount of unpaid tax against a later remittance of tax.

68.7(1) To qualify for the credit, the supplier must notify the department in writing of the uncollectible account no later than ten calendar days after the due date for payment of the tax.
Notification is to be sent to the Iowa Department of Revenue, Examination Section, Compliance Division, P. O. Box 10456, Des Moines, Iowa 50306-0456.

68.7(2) A supplier does not qualify for the credit if the purchaser did not elect to apply for the eligible purchaser or end user status or did not qualify to be an eligible purchaser. Likewise, the credit does not apply if the supplier sells additional fuel to a delinquent eligible purchaser or end user after notifying the department that the supplier has an uncollectible debt with an eligible purchaser.

68.7(3) Upon notification from the supplier that an eligible purchaser is in default of the tax payment, that person’s eligible purchaser or end user status will be canceled by the department. The eligible purchaser or end user status will not be reinstated until such time as the purchaser posts securities to guarantee future tax payments as provided in 701—paragraph 67.21(1) “d.”

68.7(4) Eligible purchaser. Any distributor of motor fuel or special fuel or end user of special fuel who requests authorization to make delayed payments of the motor vehicle fuel tax must first register with the department to obtain the eligible purchaser status.

The eligible purchaser must pay the tax to the supplier by electronic funds transfer one business day prior to the date the tax is to be paid by the supplier.

Once approved, the eligible purchaser status is valid until voluntarily canceled by the eligible purchaser or canceled by the department of revenue. See 701—subrule 67.23(4).

This rule is intended to implement Iowa Code section 452A.8 as amended by 1995 Iowa Acts, chapter 155.

701—68.8(452A) Refunds. Refunds are allowable for the tax paid on motor fuel and undyed special fuel in the following situations:

68.8(1) Federal government. Fuel sold to the United States or to any agency or instrumentality of the United States. The tax is subject to refund regardless of how the fuel is used. The following factors, among others, will be considered in determining if any organization is an instrumentality of the United States government: (a) whether it was created by the federal government, (b) whether it is wholly owned by the federal government, (c) whether it is operated for profit, (d) whether it is “primarily” engaged in the performance of some “essential” government function, and (e) whether the tax will impose an economic burden upon the federal government or serve to materially impair the usefulness and efficiency of the organization or to materially restrict it in the performance of its duties if it were imposed. Unemployment Compensation Commission v. Wachovia Bank & Trust Company, 215 N.C. 491, 2 S.E.2d 592 (1939); 1976 O.A.G. 823, 827. The American Red Cross, Project Head Start, Federal Land Banks and Federal Land Bank Associations, among others, have been determined to be instrumentalities of the federal government. Receivers or trustees appointed in the federal bankruptcy proceedings are subject to the excise tax. Wood Brothers Construction Co. v. Bagley, 232 Iowa 902, 6 N.W.2d 397 (1942).

The refund is not available to employees of the federal government who purchase fuel individually and are later reimbursed by the federal government. The name of the federal agency must appear on the invoice as the purchaser of the fuel or the refund will not be allowed.

68.8(2) Transit systems. Fuel sold to an Iowa urban transit system as defined in 701—67.1(452A) or a company operating a taxicab service under contract with an Iowa urban transit system which is used for a purpose specified in Iowa Code section 452A.57(6) and fuel sold to a regional transit system as defined in 701—67.1(452A) which is used for a purpose specified in Iowa Code section 452A.57(11).

68.8(3) The state and political subdivisions. Fuel sold to the state of Iowa or any political subdivision of the state which is used for public purposes.

The refund is not available to agencies or instrumentalities of a political subdivision, but rather only to the state of Iowa, agencies of the state of Iowa, and political subdivisions of the state of Iowa. The general attributes and factors in determining if an entity is a political subdivision of the state of Iowa are: (a) the entity has a specific geographic area, (b) the entity has public officials elected at public elections, (c) the entity has taxing power, (d) the entity has a general public purpose or benefit, and (e) the foregoing attributes, factors or powers were delegated to the entity by the state of Iowa. (1976 O.A.G. 823)

The refund is also not available to employees of a governmental unit who purchase fuel individually and are later reimbursed by the governmental unit. The name of the governmental unit must appear on
the invoice as the purchaser of the fuel or the refund will not be allowed. *Alabama v. King & Boozer*, 314 U.S. 1 (1941).

### 68.8(4) Contract carriers. 
Motor fuel and undyed special fuel sold to a contract carrier who has a contract with a public school under Iowa Code section 285.5 for the transportation of pupils of an approved public or nonpublic school is refundable. If the contract carrier also uses fuel for purposes other than the transportation of pupils, the refund will be based on that percentage of the total amount of fuel purchased which reflects the pupil transportation usage.

A refund requested by contract carriers will be reduced by the applicable sales tax unless otherwise exempt. The name of the contract carrier must appear on the invoice as the purchaser of the fuel or the refund will not be allowed. *Alabama v. King & Boozer*, 314 U.S. 1 (1941).

### 68.8(5) 
Fuel used in unlicensed vehicles, stationary engines, machinery and equipment used for nonhighway purposes, implements used in agricultural production, and fuel used for home heating.

### 68.8(6) Fuel used for producing denatured alcohol.

### 68.8(7) 
Fuel used in the watercraft of a commercial fisher, licensed and operating under an owner’s certificate for commercial fishing gear issued pursuant to Iowa Code section 482.4.

### 68.8(8) Fuel placed in motor vehicles, whether registered or not registered, not operated on public highways, and used in the extraction and processing of natural deposits.

### 68.8(9) 
Idle time. Persons who wish to claim a refund for idle time (the engine is running but not propelling the vehicle) must first apply to the department and provide statistical information on how the refund amount will be calculated. Normally, to qualify for a refund the vehicle must be equipped with an on-board monitoring device which will record the actual time the engine is idling and the amount of fuel consumed while idling. If the device only records the idle time and not fuel used, the refund amount will be calculated at one-half gallon of fuel consumed per one hour of idle time. The computation must also consider the miles driven in Iowa versus total miles driven. The department will require a review of interstate carrier reports before approval of the computation method.

### 68.8(10) Power takeoff. 
Persons operating vehicles which have auxiliary equipment that is powered by the power takeoff may apply for a refund for that portion of the fuel used for powering the auxiliary equipment.

The person requesting the refund must furnish the department with statistical information on how the exempt percentage is established. The percentage can be established by using the following noninclusive methods.

- Determine the actual fuel usage by the hour while the auxiliary equipment is in use compared to total hours the engine is running.
- Establish total miles per gallon for the vehicle when auxiliary equipment is not in use compared to miles per gallon while the equipment is in use.
- Other computation methods to be reviewed by the department prior to approval.

It has been predetermined that tax on fuel used in the mixing of cement into concrete, the off-loading of the concrete, and the loading and off-loading of solid waste will be refunded on the basis of 30 percent of the fuel placed in the fuel supply tank of the vehicle provided proper records are maintained. Proper records shall consist of records of fills for each vehicle from tax-paid bulk storage tanks or sales tickets where fuel is purchased directly from a service station. Each vehicle must be identifiable by a unit number so the department can trace fuel usage to specific vehicles. An additional allowance will be granted where it can be substantiated through the use of separate meters which operate to measure the fuel when the vehicle is stationary or the use of separate tanks which fuel the vehicle only when the vehicle is stationary that the actual nonhighway fuel usage exceeds 30 percent.

### 68.8(11) Refrigeration units (reefers). 
Tax paid on motor fuel and undyed special fuel is subject to refund. The person must maintain records of fuel purchases to substantiate the tax-paid purchases. Invoices must meet the criteria set forth in rule 701—67.12(452A). In addition, the invoices must separately state fuel purchased and placed in the reefer unit. Liquefied petroleum gas may be purchased tax-free for use in reefer units. See rule 701—69.10(452A).

### 68.8(12) Pumping credits. 
A refund will be allowed for taxes paid on fuel once that fuel has been placed in the fuel supply tank of a motor vehicle when the motor of that vehicle is used as a power
source for off-loading procedures. Meter readings from the pump used in the off-loading procedure or the invoice, manifest or bill of lading number covering the product off-loaded must be retained. The claims for refund, unless a different amount can be proven, will be (a) one-half gallon credit for each 1,000 gallons of liquid products pumped and three-tenths of a gallon credit for each ton of dry products pumped when using motor fuel or special fuel (diesel) to power the motor and (b) one gallon credit for each 1,000 gallons of liquid products pumped and three-tenths of a gallon credit for each ton of dry products pumped when using special fuel (L.P.G.) to power the motor.

68.8(13) Transport diversions. When a transport load of motor fuel or undyed special fuel is sold tax-paid with a destination in this state and later diverted to a destination outside the state, the person who actually paid the Iowa tax is entitled to a refund. To secure a refund, the person must file a completed claim form provided by the department with supporting documentation including a copy of the bill of lading, invoices or document showing where and to whom the fuel was delivered, a copy of the reporting form and evidence of payment to the state where the fuel was actually delivered.

68.8(14) Casualty loss. In the event fuel is lost or destroyed through fire, explosion, lightning, flood, storm, earthquake, terrorist attack, or other casualty, the taxpayer must inform the department in writing of such loss within 10 days of the loss; and the notification must contain the amount of gallonage lost or destroyed which must be in excess of 100 gallons. An application for refund must be submitted to the department within 60 days of the notification and contain a notarized affidavit sworn to by the person having immediate custody of the fuel at the time of the loss or destruction setting forth, in full detail, the circumstances of the loss or destruction and the number of gallons. If the fuel was in storage where several fuel purchases were commingled, it is a rebuttable presumption that the fuel lost through casualty was a part of the last delivery into the storage just prior to the loss. No refund is allowable for fuel lost through evaporation, theft, normal leakage, or unknown causes. Leakage resulting from a major accident or catastrophe is subject to refund.

68.8(15) Exports by eligible purchasers (distributors). Distributors who have purchased tax-paid motor fuel or undyed special fuel and sell the fuel to consumers outside the state may apply for a refund of the Iowa tax paid. The distributor must retain records as provided in rule 701—67.3(452A) to support the request for refund.

68.8(16) Blending errors for special fuel. Dyed special fuel commingled with undyed special fuel and motor fuel commingled with special fuel. If dyed special fuel is inadvertently mixed with tax-paid undyed special fuel to the extent that the undyed fuel must have additional dye added to meet federal dying requirements to qualify as exempt dyed fuel, the tax is refundable on the undyed special fuel. The refund request must contain the number of gallons of undyed fuel lost through the mixing error and documentation as to how the gallonage was determined. If motor fuel is blended in error with dyed special fuel to produce a commingled product that must be destroyed or refined for subsequent use, the tax-paid fuel is subject to refund. The request for refund must contain documentation that the commingled product was destroyed or sold for purposes of refinement at a terminal.

68.8(17) Watercraft. Special fuel used in watercraft. This subrule is retroactive to July 1, 1996.

68.8(18) Refund of tax—Indians. Sales by Indians to other Indians of their own tribe on federally recognized Indian reservations or settlements of which they are tribal members are exempt from the tax. However, Indian sellers are subject to the record-keeping requirements of Iowa Code chapter 452A. The fuel must be purchased by the Indian seller with the tax included in the purchase price, unless the seller’s status as a particular licensee authorizes the seller to purchase fuel tax-free. The tax exemption is allowed to the Indian purchaser by the purchaser’s filing a claim for refund of the tax paid or the tribe of which the Indian purchaser is a member filing a claim for refund of the tax paid by the tribe on fuel sold to the Indian purchaser.

68.8(19) Racing fuel.

68.8(20) Benefited fire districts if the fuel is used for public purposes.

This rule is intended to implement Iowa Code section 452A.17 as amended by 2005 Iowa Acts, House File 216, and Iowa Code section 452A.71.
701—68.9(452A) Claim for refund—payment of claim. In order to receive a refund, the claimant must hold a refund permit.

68.9(1) Persons requesting a refund for fuel used for any exempt purpose will do so by providing all or a portion of the following: (a) refund permit number, (b) type of fuel, (c) total number of gallons/tons of fuel used to calculate the refund amount, (d) the beginning and ending dates of the tax period, (e) net cost of fuel, (f) Iowa sales tax due (net cost of fuel times sales tax rate), (g) other items depending on the type of permit and claim type, (h) the total amount of refund claimed, and (i) additional information as required.

Persons requesting a refund for casualty loss, transport diversions, blending errors of motor fuel and alcohol, and blending errors of special fuel must file in writing on the forms provided by the department and must attach supporting documents explaining why a refund is due.

68.9(2) Refunds are made and the amount of the refund is paid to the person who actually paid the tax with the following exception: Persons requesting a refund for idle time, power takeoff, reefer units, pumping credits, or transport diversions may designate another person as an agent to file the claim and receive the refund. The person acting as an agent for others must provide the department with the following information including, but not limited to, the name, address, and federal identification number or social security number of the person on whose behalf they are requesting the refund. Once a person is designated as an agent, this designation remains in force until the department is notified in writing the agency agreement no longer exists. A governmental agency may designate another governmental agency as an agent for filing and receiving any tax refund authorized in Iowa Code section 452A.17.

68.9(3) Deposit of refund. If the person so designates on the application, the department will direct deposit the refund in the person’s designated bank account. If this option is selected on the application, additional forms will be provided to secure the needed information for direct deposit. In lieu of direct deposit, the permit holder will receive a state warrant.

68.9(4) A claim for refund will not be allowed unless the claimant has accumulated $60 in credits for one calendar year. A claim for refund may be filed anytime the $60 minimum has been met within the calendar year. If the $60 minimum has not been met in the calendar year, the credit must be claimed on the claimant’s income tax return unless the claimant is not required to file an income tax return in which case a refund will be allowed. An income tax credit may not be claimed for any year in which a claim for refund was filed. Once the $60 minimum has been met, the claim for refund must be filed within one year if met prior to July 1, 2002, and within three years if met on or after July 1, 2002.

EXAMPLE: A claim for refund in the amount of $200 is filed in March of 1996. During the remainder of 1996 an additional $50 in credits is accumulated. The claimant cannot claim this $50 credit on the claimant’s 1996 income tax return because an income tax credit cannot be filed for any year in which a claim for refund was filed. The claimant must file a claim for refund of the $50 even though it is below the $60 minimum.

EXAMPLE: The claimant does not have a refund permit. The claimant accumulates $40 in credits during January of 2002 and $50 in credits during June of 2002. The claimant may claim a $90 credit on the claimant’s 2002 income tax return or apply for a refund permit and claim a refund within one year of June 2002 which is the date the $60 minimum was met. If the $60 minimum is met on or after July 1, 2002, the claim for refund must be filed within three years of the date the $60 minimum was met.

68.9(5) A refund will not be paid with respect to any motor fuel taken out of this state in supply tanks of watercraft, aircraft, or motor vehicles or any undyed special fuel taken out of this state in aircraft or motor vehicles.


This rule is intended to implement Iowa Code sections 452A.17, 452A.19, 452A.21, and 452A.72 as amended by 2002 Iowa Acts, Senate File 2305.

701—68.10(452A) Refund permit. To obtain the refund provided for in Iowa Code chapter 452A and rule 68.8(452A), the claimant must have an uncanceled refund permit. The application for a refund permit is provided by the department and will contain, but not be limited to, the following information: (1) the name and location of the business and the mailing address if different, (2) the type of ownership,
(3) the social security number or federal identification number of the applicant, and (4) the type of refund requested. The refund permit is issued without cost and remains in effect until revoked, canceled or until the permit becomes invalid. All refund permit holders are required to keep invoices and copies of returns if filed, supporting schedules and studies for documentation to support the refund.

This rule is intended to implement Iowa Code section 452A.18 as amended by 1995 Iowa Acts, chapter 155.

701—68.11(452A) Revocation of refund permit. The following violations will result in the revocation of the permit: (1) using a false or altered invoice in support of a claim, (2) making a false statement in a claim for refund or in response to an investigation by the department of a claim for refund, (3) refusal to submit the claimant’s books and records for examination by the department, and (4) nonuse for a period of three years. If the permit is revoked for reason (1), (2), or (3) above, the permit will not be reissued for a period of at least one year. If the permit is revoked for reason (4) above, the permit will be reissued upon proper application. (See rule 701—7.23(17A) for revocation procedure.)

This rule is intended to implement Iowa Code section 452A.19.

[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—68.12(452A) Income tax credit in lieu of refund. In lieu of applying for a refund permit, a person or corporation may claim the refund allowable under Iowa Code section 452A.17 as an income tax credit. If a person or corporation holds a refund permit and elects to receive an income tax credit, the person or corporation must cancel the refund permit within 30 days after the first day of its year or the permit becomes invalid and application must be made for a new permit. Once the election to receive an income tax credit has been made, it remains in effect until the election is changed. The income tax credit is not available for refunds relating to casualty losses, transport diversions, pumping credits, blending errors, idle time, power takeoffs, reefer units, exports by distributors, and excess tax paid on ethanol blended gasoline.

This rule is intended to implement Iowa Code sections 422.110, 452A.17(2), and 452A.21 as amended by 1999 Iowa Acts, Senate File 136.

701—68.13(452A) Reduction of refund—sales and use tax. Under Iowa Code section 423.3(56), the sales price from the sale of motor fuel and special fuel consumed for highway use or in watercraft or aircraft where the fuel tax has been imposed and paid, and no refund has been or will be allowed, is exempt from Iowa sales and use tax. Therefore, unless the fuel is used for some other exempt purpose under Iowa Code section 423.3 (e.g., used for processing, used for agricultural purposes, used by an exempt government entity, used by a private nonprofit educational institution), or the fuel is lost through a casualty, the refund of taxes on motor fuel or special fuel will be reduced by the applicable sales and use tax. See sales tax rule 701—18.37(422,423). The sales price upon which the sales and use tax will be applied shall include all federal excise taxes, but will not include the Iowa fuel tax. Gurley v. Rhoden, 421 U.S. 200 (1975).

This rule is intended to implement Iowa Code section 452A.17.

[ARC 2247C, IAB 11/25/15, effective 12/30/15]

701—68.14(452A) Terminal withdrawals—meters. Any refinery or terminal within this state must be fixed with meters which totalize the gross gallons withdrawn. All bills of lading or manifests must show the gross gallons withdrawn. A temperature-adjusted or other method shall not be used except as it applies to liquefied petroleum gas and the sale or exchange of petroleum products between petroleum refiners. All fuel withdrawn from a refinery or terminal within this state must pass through these meters.

This rule is intended to implement Iowa Code sections 452A.2, 452A.8, 452A.15(2), and 452A.59 as amended by 1995 Iowa Acts, chapter 155.

701—68.15(452A) Terminal and nonterminal storage facility reports and records. Each terminal and nonterminal storage facility operating in Iowa must file a monthly inventory report with the department. The report shall include, but not be limited to, the following information:
1. The name and license number of the company that owns and operates the terminal or nonterminal storage facility.
2. The location of the terminal or nonterminal storage facility.
3. The month and year covered by the report.
4. The terminal code assigned by the Internal Revenue Service or the storage facility license number assigned by the department.
5. The beginning inventory.
6. The total receipts for the month including for each receipt: (a) the gross gallons received by schedule code, by fuel type and, if diesel fuel, whether dyed or undyed fuel, (b) the bill of lading number, (c) the date of receipt, (d) the seller, (e) the carrier, (f) the mode of transportation, and (g) the destination state.
7. The total withdrawals for the month, including for each withdrawal: (a) the gross gallons withdrawn by schedule code and by fuel type and, if diesel fuel, whether dyed or undyed fuel, (b) the bill of lading number, (c) the date of withdrawal, (d) the consignor, (e) the consignee, (f) the mode of transportation, (g) the destination state, (h) the origin state, and (i) the carrier.
8. The actual ending inventory and any gains or losses.
9. The signature or electronic signature of the person responsible for preparing the report.
10. Such additional information as the department may require.

For periods beginning on or after July 1, 2002, the director may impose a civil penalty against any person who fails to file the reports required under the motor fuel tax laws. The penalty shall be $100 for the first violation and shall increase by $100 for each additional violation occurring in the calendar year in which the first violation occurred.

The director may require that reports be filed by electronic transmission. All licensees must file reports by electronic transmission beginning September 1, 2006.

This rule is intended to implement Iowa Code section 452A.15(2).

701—68.16(452A) Method of reporting taxable gallonage. The exclusive method of determining gallonage of any purchase or sale of motor fuel or special fuel and distillate fuel is to be on gross-volume basis. A temperature-adjusted or other method cannot be used, except as it applies to liquefied petroleum gas and the sale or exchange of petroleum products between petroleum refineries.

This rule is intended to implement Iowa Code section 452A.8 as amended by 1995 Iowa Acts, chapter 155.

701—68.17(452A) Transportation reports. The reports required under Iowa Code section 452A.15(1) are to be filed by railroad carriers, common carriers, contract carriers, distributors transporting fuel for others, and anyone else transporting fuel from without the state and unloading it at other than terminal storage within the state. The report must include all fuel which was imported into Iowa and unloaded at other than terminal storage, all fuel withdrawn from Iowa terminal storage and delivered in Iowa, and all fuel withdrawn from Iowa terminal storage and exported from Iowa. These reports must be filed monthly and show as to each delivery:
1. The name, address, and federal identification number or social security number of the person to whom actually delivered.
2. The name, address, and federal identification number or social security number of the originally named consignee, if delivered to anyone other than the originally named consignee.
3. The point of origin, the point of delivery, and the date of delivery.
4. The number and initials of each tank car and the number of gallons contained therein, if shipped by rail.
5. The name of the boat, barge, or vessel, and the number of gallons contained therein, if shipped by water.
6. The registration number of each tank truck and the number of gallons contained therein, if transported by motor truck.
7. The manner, if delivered by other means, in which the delivery is made.
8. Such additional information relative to shipments of motor fuel or special fuel as the department may require.

For periods on or after July 1, 2002, the director may impose a civil penalty against any person who fails to file the reports required under the motor fuel tax laws. The penalty shall be $100 for the first violation and shall increase by $100 for each additional violation occurring in the calendar year in which the first violation occurred.

The director may require that reports be filed by electronic transmission.

This rule is intended to implement Iowa Code section 452A.15 as amended by 2002 Iowa Acts, House File 2622 and Senate File 2305.

701—68.18(452A) Bill of lading or manifest requirements. Whenever a bill of lading or manifest is required to be issued, carried, retained, or submitted by these rules, it shall meet the following minimum requirements:

1. Contain the name and address of the refinery, terminal, ethanol plant, biodiesel plant or point of origin.
2. Contain the date of withdrawal or import.
3. Contain the name of the shipper-supplier-consignor.
4. Contain the name of the purchaser-consignee.
5. Contain the place of actual destination.
6. Contain the name of the transporter.
7. Contain the gross gallons by fuel type.
8. Contain the designation for ethanol blended gasoline or biodiesel blended fuel as provided in Iowa Code section 214A.2.
9. Contain a statement designating whether diesel fuel is dyed or undyed.
10. Have machine printed thereon a serial number of not less than four digits.

This rule is intended to implement Iowa Code sections 452A.10, 452A.12, 452A.60, and 452A.76.
[ARC 8225B, IAB 10/7/09, effective 11/11/09]

701—68.19(452A) Right of distributors and dealers to blend conventional blendstock for oxygenate blending, gasoline, or diesel fuel using a biofuel.

68.19(1) A dealer or distributor may blend a conventional blendstock for oxygenate blending, gasoline, or diesel fuel using the appropriate biofuel, or sell unblended or blended gasoline or diesel fuel on any premises in this state. This subrule does not apply to the extent that the use of the premises is restricted by federal, state, or local law.

68.19(2) A refiner, supplier, terminal operator, or terminal owner who in the ordinary course of business sells or transports a conventional blendstock for oxygenate blending, gasoline unblended or blended with a biofuel, or diesel fuel unblended or blended with a biofuel shall not refuse to sell or transport to a distributor or dealer any conventional blendstock for oxygenate blending, unblended gasoline, or unblended diesel fuel that is at the terminal, based on the distributor’s or dealer’s intent to use the conventional blendstock for oxygenate blending, or blend the gasoline or diesel fuel with a biofuel.

68.19(3) This rule shall not be construed to do any of the following:

a. Prohibit a distributor or dealer from purchasing, selling or transporting a conventional blendstock for oxygenate blending, gasoline that has not been blended with a biofuel, or diesel fuel that has not been blended with a biofuel.

b. Affect the blender’s license requirements under Iowa Code section 452A.6.

c. Prohibit a dealer or distributor from leaving a terminal with a conventional blendstock for oxygenate blending, gasoline that has not been blended with a biofuel, or diesel fuel that has not been blended with a biofuel.

d. Require a nonrefiner biofuel manufacturer to offer or sell a conventional blendstock for oxygenate blending, gasoline that has not been blended with a biofuel, or diesel fuel that has not been blended with a biofuel.
68.19(4) A refiner, supplier, terminal operator, or terminal owner who violates this rule is subject to a civil penalty of not more than $10,000 per violation. Each day that a violation continues is deemed a separate offense. For more information on enforcement of this penalty, see 701—subrule 10.71(8).

This rule is intended to implement Iowa Code section 452A.6A.

[ARC 1442C, IAB 4/30/14, effective 6/4/14]

[Filed 11/3/95, Notice 9/27/95—published 11/22/95, effective 1/1/96]
[Filed 9/20/96, Notice 8/14/96—published 10/9/96, effective 11/13/96]
[Filed 9/5/97, Notice 7/30/97—published 9/24/97, effective 10/29/97]
[Filed 5/11/01, Notice 2/21/01—published 5/30/01, effective 7/4/01]
[Filed 10/12/01, Notice 9/15/01—published 10/31/01, effective 12/5/01]
[Filed 10/25/02, Notice 9/4/02—published 11/13/02, effective 12/18/02]
[Filed 11/6/03, Notice 10/1/03—published 11/26/03, effective 12/31/03]
[Filed 10/22/04, Notice 9/15/04—published 11/10/04, effective 12/15/04]
[Filed 11/16/05, Notice 10/12/05—published 12/7/05, effective 1/11/06]
[Filed 12/13/06, Notice 11/8/06—published 1/3/07, effective 2/7/07]
[Filed 8/22/07, Notice 7/18/07—published 9/12/07, effective 10/17/07]
[Filed 10/5/07, Notice 8/29/07—published 10/24/07, effective 11/28/07]
[Filed 2/8/08, Notice 1/2/08—published 2/27/08, effective 4/2/08]
[Filed 10/31/08, Notice 9/24/08—published 11/19/08, effective 12/24/08]
[Filed ARC 8225B (Notice ARC 8043B, IAB 8/12/09), IAB 10/7/09, effective 11/11/09]
[Filed ARC 0251C (Notice ARC 0145C, IAB 5/30/12), IAB 8/8/12, effective 9/12/12]
[Filed ARC 0399C (Notice ARC 0285C, IAB 8/22/12), IAB 10/17/12, effective 11/21/12]
[Filed ARC 1442C (Notice ARC 1362C, IAB 3/5/14), IAB 4/30/14, effective 6/4/14]
[Filed ARC 1805C (Notice ARC 1681C, IAB 10/15/14), IAB 1/7/15, effective 2/11/15]
[Filed ARC 2247C (Notice ARC 2123C, IAB 9/2/15), IAB 11/25/15, effective 12/30/15]
[Filed ARC 2698C (Notice ARC 2619C, IAB 7/6/16), IAB 8/31/16, effective 10/5/16]
[Filed ARC 3146C (Notice ARC 3036C, IAB 4/26/17), IAB 6/21/17, effective 7/26/17]
[Filed ARC 4252C (Notice ARC 4133C, IAB 11/21/18), IAB 1/16/19, effective 2/20/19]
[Filed ARC 4585C (Notice ARC 4381C, IAB 4/10/19), IAB 7/31/19, effective 9/4/19]
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761—600.3(21) Definitions. The definitions in Iowa Code section 321.1 and the following definitions apply to the rules in 761—Chapters 600 to 699.

“Director of the driver and identification services bureau” includes the bureau director’s designee.

“License” means “driver’s license” as defined in Iowa Code section 321.1(20A) unless the context otherwise requires.

This rule is intended to implement Iowa Code section 321.1.

[ARC 0661C, IAB 4/3/13, effective 5/8/13; ARC 4586C, IAB 7/31/19, effective 9/4/19]

761—600.3(17A) Information and location. Applications, forms and information concerning driver’s licensing are available at any driver’s license service center. Assistance is also available by mail from the Driver and Identification Services Bureau, Iowa Department of Transportation, P.O. Box 9204, Des Moines, Iowa 50306-9204; in person at 6310 SE Convenience Blvd., Ankeny, Iowa; by telephone at (515)244-8725; by facsimile at (515)239-1837; or on the department’s website at www.iowadot.gov.

This rule is intended to implement Iowa Code section 17A.3.

[ARC 4586C, IAB 7/31/19, effective 9/4/19]

761—600.3(321) Seat belt exemptions.

600.3(1) A person who is unable to wear a safety belt or safety harness for physical or medical reasons may obtain a form to be signed by the person’s health care provider licensed under Iowa Code chapter 148 or 151. Form No. 432017, “Iowa Medical Safety Belt Exemption,” is available from the driver and identification services bureau.

600.3(2) Iowa Code sections 321.445(1) and 321.445(2) shall not apply to the front seats and front seat passengers of motor vehicles owned, leased or primarily used by a person with a physical disability who uses a collapsible wheelchair.

This rule is intended to implement Iowa Code section 321.445.

[ARC 9991B, IAB 2/8/12, effective 3/14/12; ARC 4586C, IAB 7/31/19, effective 9/4/19]

Two or more ARCs

Effective date of 761—600.13(321) delayed 70 days by the Administrative Rules Review Committee at its meeting held December 9, 1998. At its meeting held January 5, 1999, the Committee delayed the effective date until adjournment of the 1999 Session of the General Assembly.
CHAPTER 602
CLASSES OF DRIVER’S LICENSES

761—602.1(321) Driver’s licenses.

602.1(1) Classes. The department issues the following classes of driver’s licenses. All licenses issued, including special licenses and permits, shall carry a class designation. A license shall be issued for only one class, except that Class M may be issued in combination with another class.

Class A—commercial driver’s license (CDL)
Class B—commercial driver’s license (CDL)
Class C—commercial driver’s license (CDL)
Class C—noncommercial driver’s license
Class D—noncommercial driver’s license (chauffeur)
Class M—noncommercial driver’s license (motorcycle)

602.1(2) Special licenses and permits. The department issues the following special licenses and permits. More than one type of special license or permit may be issued to an applicant. On the driver’s license, a restriction number designates the type of special license or permit issued, as follows:

1—Motorcycle instruction permit—includes motorcycle instruction permits issued under Iowa Code subsections 321.180(1) and 321.180B(1)
2—Noncommercial instruction permit (vehicle less than 16,001 gross vehicle weight rating)—includes instruction permits, other than motorcycle instruction permits, issued under Iowa Code subsection 321.180(1), section 321.180A and subsection 321.180B(1)
3—Commercial learner’s permit
4—Chauffeur’s instruction permit
5—Motorized bicycle license
6—Minor’s restricted license
7—Minor’s school license

602.1(3) Commercial driver’s license (CDL). See 761—Chapter 607 for information on the procedures, requirements and validity of a commercial driver’s license (Classes A, B and C) and a commercial learner’s permit, and their restrictions and endorsements.

This rule is intended to implement Iowa Code sections 321.178, 321.180, 321.180A, 321.180B, 321.189, and 321.194.
[ARC 2071C; IAB 8/5/15, effective 7/14/15; ARC 2337C; IAB 1/6/16, effective 2/10/16; ARC 2644C, IAB 8/3/16, effective 9/7/16]

761—602.2(321) Information and forms. Applications, forms and information about driver’s licensing are available at any driver’s license service center. Assistance is also available by mail from Driver and Identification Services, Iowa Department of Transportation, P.O. Box 9204, Des Moines, Iowa 50306-9204; in person at 6310 SE Convenicne Blvd., Ankeny, Iowa; by telephone at (515)244-8725; by facsimile at (515)239-1837; or on the department’s website at www.iowadot.gov.

602.2(1) Certificate of completion. Form 430036 shall be used to submit proof of successful completion of an Iowa-approved course in driver education, motorcycle rider education or motorized bicycle education, except that proof of successful completion of an Iowa-approved course in driver education may instead be submitted through an online reporting system used by participating Iowa-approved driver education schools.

a. If a student completed a course in another state, a public or licensed commercial or private provider of the Iowa-approved course may issue the form or online completion, if applicable, for the student if the provider determines that the out-of-state course is comparable to the Iowa-approved course.

b. If the out-of-state course is comparable but lacks certain components of the Iowa-approved course, the provider may issue the form or online completion, if applicable, after the student completes the missing components.

602.2(2) Affidavit for school license. Form 430021 shall be used for submitting the required statements, affidavits and parental consent for a minor’s school license. See rule 761—602.26(321).
602.2(3) Waiver of accompanying driver for intermediate licensee. Form 431170 is the waiver described in Iowa Code subsection 321.180B(2). This form allows an intermediate licensee to drive unaccompanied between the hours of 12:30 a.m. and 5 a.m. and must be in the licensee’s possession when the licensee is driving during the hours to which the waiver applies.

a. If the waiver is for employment, the form must be signed by the licensee’s employer.

b. If the licensee attends a public school and the waiver is for school-related extracurricular activities, the form must be signed by the chairperson of the school board, the superintendent of the school, or the principal of the school if authorized by the superintendent. If the licensee attends an accredited nonpublic school and the waiver is for school-related extracurricular activities, the form must be signed by an authority in charge of the accredited nonpublic school or a duly authorized representative of the authority.

c. The form must be signed by the licensee’s parent or guardian. However, the parent’s or guardian’s signature is not required if the licensee is married and the original or a certified copy of the marriage certificate is in the licensee’s possession when the licensee is driving during the hours to which the waiver applies.

602.2(4) Passenger restriction for intermediate licensee. The passenger restriction required by Iowa Code subsection 321.180B(2) will be added to an intermediate license unless waived by the licensee’s parent or guardian at the time the license is issued. If the restriction is not waived at the time the license is issued, the intermediate license will be designated with a “9” restriction with the following notation: “Only 1 unrelated minor passenger allowed until [six months from the date the license is issued].” The licensee must obey the restriction for the first six months after the intermediate license is issued. If a parent or guardian wishes to waive the passenger restriction after the license has already been issued, the licensee and the parent or guardian must apply for a duplicate license and pay the replacement fee pursuant to 761—subrule 605.11(3).

This rule is intended to implement Iowa Code sections 321.8, 321.178, 321.180B, 321.184, 321.189, and 321.194.

[ARC 7902B, IAB 7/1/09, effective 8/5/09; ARC 2644C, IAB 8/3/16, effective 9/7/16; ARC 4271C, IAB 1/30/19, effective 3/6/19]

761—602.3(321) Examination and fee. Rescinded IAB 8/9/00, effective 7/24/00.

761—602.4(321) Definitions of immediate family.

602.4(1) A “member of the permittee’s immediate family” as used in Iowa Code subsection 321.180(1) means the permittee’s parent or guardian or a brother, sister or other relative of the permittee who resides at the permittee’s residence.

602.4(2) A “member of the permittee’s immediate family” as used in Iowa Code section 321.180B, subsections 1 and 2, means a brother, sister or other relative of the permittee who resides at the permittee’s residence.

This rule is intended to implement Iowa Code sections 321.180 and 321.180B.

761—602.5 to 602.10 Reserved.

761—602.11(321) Class C noncommercial driver’s license. This rule describes a noncommercial Class C driver’s license that is not a special license or permit.

602.11(1) Validity and issuance.

a. The license is valid for operating:

(1) A motor vehicle, including an autocycle as defined in Iowa Code section 321.1, that does not require a commercial driver’s license or a Class D driver’s license for its operation.

(2) A motorized bicycle.

(3) A motorcycle only if the license has a motorcycle endorsement.

b. The license is issued for either two years or eight years.

(1) A qualified applicant who is at least 17 years, 11 months of age but not yet 72 years of age shall be issued an eight-year license. However, the expiration date of the license issued shall not exceed the licensee’s 74th birthday.
(2) A two-year license shall be issued to a qualified applicant who is under 17 years, 11 months of age or who is 72 years of age or older.

(3) A two-year license may also be issued, at the discretion of the department, to an applicant whose license is restricted due to vision or other physical disabilities.

602.11(2) Requirements.

a. An applicant shall be at least 16 years of age.

b. Except as otherwise provided in Iowa Code subsection 321.178(3), an applicant under 18 years of age must meet the requirements of Iowa Code section 321.180B and submit proof of successful completion of an Iowa-approved course in driver education.

c. For purposes of determining eligibility for an intermediate license issued to a person 16 or 17 years of age under Iowa Code subsection 321.180B(2):

(1) The 12-month period during which the applicant is required to possess an instruction permit before applying for an intermediate license shall be calculated cumulatively and shall include any period of time during which the applicant has held a valid instruction permit issued under Iowa Code subsection 321.180B(1), a minor’s school license issued under Iowa Code section 321.194, or comparable instruction permit or license issued by another state, but shall exclude any period of time during which the permit or license is suspended, revoked, or canceled, or the applicant otherwise did not have a valid driving privilege.

(2) The six-month period during which the applicant is required to remain accident and violation free shall be calculated continuously and must encompass without interruption the six-month period of time immediately preceding the application. The applicant must hold a valid instruction permit issued under Iowa Code subsection 321.180B(1), a minor’s school license issued under Iowa Code section 321.194, or a comparable instruction permit or license issued by another state and maintain a valid driving privilege without interruption throughout the continuous six-month period.

d. For purposes of determining eligibility for a full license issued to a person 17 years of age under Iowa Code subsection 321.180B(4), the 12-month period during which the applicant is required to possess an intermediate license and to remain accident and violation free before applying for a full license shall be calculated together and continuously and must encompass without interruption the 12-month period of time immediately preceding the application. The applicant must hold a valid intermediate license issued under Iowa Code subsection 321.180B(2) or a comparable license issued by another state and maintain a valid driving privilege without interruption throughout the continuous 12-month period.

This rule is intended to implement Iowa Code sections 321.1, 321.177, 321.178, 321.180B, 321.189 and 321.196.

[ARC 1714C, IAB 11/12/14, effective 12/17/14; ARC 2644C, IAB 8/3/16, effective 9/7/16; ARC 2985C, IAB 3/15/17, effective 4/19/17]

761—602.12(321) Class D noncommercial driver’s license (chauffeur). This rule describes a noncommercial Class D driver’s license.

602.12(1) Validity and issuance.

a. The license is valid for operating:

(1) A motor vehicle as a chauffeur as specified by the endorsement on the license, unless the type of vehicle or type of operation requires a commercial driver’s license.

(2) A motor vehicle that may be legally operated under a noncommercial Class C driver’s license, including a motorized bicycle.

(3) A motorcycle only if the license has a motorcycle endorsement.

b. The license shall have one endorsement authorizing a specific type of motor vehicle or type of operation, as listed in 761—subrule 605.7(3). The gross vehicle weight rating shall be determined pursuant to rule 761—604.35(321).

c. The license is issued for either two years or eight years.

(1) A qualified applicant who is at least 18 years of age but not yet 72 years of age shall be issued an eight-year license. However, the expiration date of the license issued shall not exceed the licensee’s 74th birthday.
(2) A two-year license shall be issued to a qualified applicant who is 72 years of age or older.

(3) A two-year license may also be issued, at the discretion of the department, to an applicant whose license is restricted due to vision or other physical disabilities.

**602.12(2) Requirements.**

a. An applicant shall be at least 18 years of age.

b. Reserved.

This rule is intended to implement Iowa Code sections 321.1, 321.177, 321.189, and 321.196.

[ARC 1714C, IAB 11/12/14, effective 12/17/14; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 4586C, IAB 7/31/19, effective 9/4/19]

**761—602.13(321) Class M noncommercial driver’s license (motorcycle).** This rule describes a noncommercial Class M driver’s license that is not a special license or permit.

**602.13(1) Validity and issuance.**

a. The license is valid for operating:

1. A motorcycle. However, the license may have a restriction which limits operation to a three-wheel motorcycle.

2. A motorized bicycle.

b. The license is issued for either two years or eight years.

1. A qualified applicant who is at least 17 years, 11 months of age but not yet 72 years of age shall be issued an eight-year license. However, the expiration date of the license issued shall not exceed the licensee’s 74th birthday.

2. A two-year license shall be issued to a qualified applicant who is under 17 years, 11 months of age or who is 72 years of age or older.

3. A two-year license may also be issued, at the discretion of the department, to an applicant whose license is restricted due to vision or other physical disabilities.

  c. An Iowa driver’s license issued before March 15, 1968, which is still valid because of an extension, is valid for motorcycles. An Iowa driver’s license issued from March 15, 1968, through June 30, 1972, which is still valid because of an extension, is valid for motorcycles unless the back of the license is stamped “Not valid for motorcycles.”

**602.13(2) Requirements.**

a. An applicant shall be at least 16 years of age.

b. Except as otherwise provided in Iowa Code subsection 321.178(3), an applicant under 18 years of age must meet the requirements of Iowa Code section 321.180B and submit proof of successful completion of an Iowa-approved course in driver education.

  c. An applicant under 18 years of age must submit proof of successful completion of an Iowa-approved course in motorcycle rider education.

This rule is intended to implement Iowa Code sections 321.177, 321.178, 321.180B, 321.189 and 321.196.

[ARC 1714C, IAB 11/12/14, effective 12/17/14]

**761—602.14(321) Transition from five-year to eight-year licenses.** During the period January 1, 2014, to December 31, 2018, the department shall issue qualified applicants otherwise eligible for an eight-year license a five-year, six-year, seven-year, or eight-year license, subject to all applicable limitations for age and ability. The applicable period shall be randomly assigned to the applicant by the department’s computerized issuance system based on a distribution formula intended to spread renewal volumes as equally as practical over the eight-year period beginning January 1, 2019, and ending December 31, 2026.

This rule is intended to implement Iowa Code section 321.196.

[ARC 1714C, IAB 11/12/14, effective 12/17/14; ARC 4271C, IAB 1/30/19, effective 3/6/19]

**761—602.15(321) Minor’s restricted license.** Renumbered as 761—602.25(321)IAB 1/8/92, effective 2/12/92.
761—602.16(321) Temporary instruction permit. Rescinded IAB 1/8/92, effective 2/12/92.

761—602.17(321) Minor’s school license. Renumbered as 761—602.26(321)IAB 1/8/92, effective 2/12/92.

761—602.18(321) Motorcycle instruction permit. This rule describes a motorcycle instruction permit issued under Iowa Code subsection 321.180(1) or 321.180B(1).

602.18(1) Validity and issuance.
   a. The motorcycle instruction permit is a permit that is added to another driver’s license.
   b. The permit is valid for operating a motorcycle when the permittee is accompanied by a person specified in Iowa Code subsection 321.180(1) or 321.180B(1), as applicable to the age of the permittee.
   c. The permit is not valid for operating a motorized bicycle.
   d. The permit is issued for four years and is not renewable.

602.18(2) Requirement. An applicant shall be at least 14 years of age.
This rule is intended to implement Iowa Code sections 321.177, 321.180 and 321.180B.

761—602.19(321) Noncommercial instruction permit. This rule describes a noncommercial instruction permit, other than a motorcycle instruction permit, issued under Iowa Code subsection 321.180(1) or 321.180B(1).

602.19(1) Validity and issuance.
   a. The permit is a restricted, noncommercial Class C driver’s license.
   b. The permit is valid for operating a motor vehicle that may be legally operated under a noncommercial Class C driver’s license when the permittee is accompanied by a person specified in Iowa Code subsection 321.180(1) or 321.180B(1), as applicable to the age of the permittee.
   c. The permit is not valid for operating a motorized bicycle.
   d. The permit is not valid as a motorcycle instruction permit.
   e. The permit is issued for four years.

602.19(2) Requirement. An applicant shall be at least 14 years of age.
This rule is intended to implement Iowa Code sections 321.177, 321.180 and 321.180B.

761—602.20 Rescinded IAB 11/18/98, effective 12/23/98.

761—602.21(321) Special noncommercial instruction permit. This rule describes a special noncommercial instruction permit issued under Iowa Code section 321.180A.

602.21(1) Validity and issuance.
   a. The permit is a restricted, noncommercial Class C driver’s license that is issued to a person whose application for driver’s license renewal has been denied or whose driver’s license has been suspended for incapability due to a physical disability.
   b. The permit is valid for operating a motor vehicle that may be legally operated under a noncommercial Class C driver’s license when the permittee is accompanied by a person specified in Iowa Code section 321.180A.
   c. The permit is not valid for operating a motorized bicycle.
   d. The permit is not valid as a motorcycle instruction permit.
   e. The permit is valid for six months from the date of issuance. It is invalid after the expiration date on the permit.
   f. The permit may be reissued for one additional six-month period.

602.21(2) Requirement. An applicant must submit a medical report as referenced in 761—subrule 605.4(6).
This rule is intended to implement Iowa Code section 321.180A.

[ARC 4586C, IAB 7/31/19, effective 9/4/19]

761—602.22 Reserved.
761—602.23(321) Chauffeur’s instruction permit.

602.23(1) Validity and issuance.
   a. A chauffeur’s instruction permit is a permit that is added to a Class D license or a noncommercial Class C license that is not a special license or permit.
   b. The license with the permit is valid for operating:
      (1) A motor vehicle that may be legally operated under the class of license (and for Class D, the endorsement) held by the licensee, including a motorized bicycle.
      (2) A motor vehicle, other than a commercial motor vehicle or a motorcycle, as a chauffeur if accompanied by a person with a valid Class D license or a commercial driver’s license valid for the vehicle being operated.
   c. The permit is issued for two years.

602.23(2) Requirements.
   a. An applicant shall be at least 18 years of age.
   b. Reserved.

This rule is intended to implement Iowa Code sections 321.1, 321.177 and 321.180.

761—602.24(321) Motorized bicycle license.

602.24(1) Validity and issuance.
   a. A motorized bicycle license is a restricted, noncommercial Class C license.
   b. The license is valid for operating a motorized bicycle.
   c. The license is issued for two years.

602.24(2) Requirements.
   a. An applicant shall be at least 14 years of age.
   b. An applicant under 16 years of age must submit proof of successful completion of an Iowa-approved course in motorized bicycle education.

This rule is intended to implement Iowa Code sections 321.177 and 321.189.

761—602.25(321) Minor’s restricted license.

602.25(1) Validity and issuance.
   a. A minor’s restricted license is a restricted, noncommercial Class C or Class M driver’s license.
   b. The license is valid for driving to and from the licensee’s place of employment or to transport dependents to and from temporary care facilities, if necessary to maintain the licensee’s present employment.
   c. The type of motor vehicle that may be operated is controlled by the class of driver’s license issued. A Class C minor’s restricted license is valid for operating a motorcycle only if the license has a motorcycle endorsement. A minor’s restricted license is valid for operating a motorized bicycle only for the purposes specified in paragraph “b” of this subrule.
   d. The license is issued for two years.

602.25(2) Requirements.
   a. The applicant shall be at least 16 years of age but not yet 18.
   b. The applicant shall submit to the department a statement from the employer confirming the applicant’s employment.
   c. Proof of nonattendance is required. Proof of nonattendance is receipt of notification from the appropriate school authority that the applicant does not attend school, as set out in 761—subrule 615.23(2).
   d. The applicant shall submit proof of successful completion of an Iowa-approved course in driver education.
   e. For a Class M minor’s restricted license or a motorcycle endorsement, the applicant shall also submit proof of successful completion of an Iowa-approved course in motorcycle rider education.

This rule is intended to implement Iowa Code sections 299.1B, 321.178, 321.180B, 321.189, 321.196 and 321.213B.
761—602.26(321) Minor’s school license.

602.26(1) Validity and issuance.

a. A minor’s school license is a restricted, noncommercial Class C or Class M driver’s license.

b. The license is valid during the times and for the purposes set forth in Iowa Code section 321.194 and at any time when the licensee is accompanied in accordance with Iowa Code section 321.180B(1).

c. The type of motor vehicle that may be operated is controlled by the class of driver’s license issued. A Class C minor’s school license is valid for operating a motorcycle only if the license has a motorcycle endorsement. A minor’s school license is valid for operating a motorized bicycle.

d. The license is issued for two years.

602.26(2) Requirements.

a. An applicant shall be at least 14 years of age but not yet 18 and meet the requirements of Iowa Code section 321.194.

b. An applicant who attends a public school shall submit a statement of necessity signed by the chairperson of the school board, the superintendent of the school, or the principal of the school if authorized by the superintendent. An applicant who attends an accredited nonpublic school shall submit a statement of necessity signed by an authority in charge of the accredited nonpublic school or a duly authorized representative of the authority. The statement shall be on Form 430021.

c. An applicant shall submit proof of successful completion of an Iowa-approved course in driver education.

d. For a Class M minor’s school license or a motorcycle endorsement, an applicant shall also submit proof of successful completion of an Iowa-approved course in motorcycle rider education.

602.26(3) Exemption.

a. An applicant is not required to have completed an approved driver education course if the applicant demonstrates to the satisfaction of the department that completion of the course would impose a hardship upon the applicant; however, the applicant must meet all other requirements for a school license. “Hardship” means:

   (1) If the applicant is 14 years old, that a driver education course will not begin at the applicant’s school(s) of enrollment or at a public school in the applicant’s district of residence within one year following the applicant’s fourteenth birthday; or

   (2) If the applicant is 15 years old, that a driver education course will not begin at the applicant’s school(s) of enrollment or at a public school in the applicant’s district of residence within six months following the applicant’s fifteenth birthday; or

   (3) If the applicant is between 16 and 18 years old, that a driver education course is not offered at the applicant’s school(s) of enrollment or at a public school in the applicant’s district of residence at the time the request for hardship status is submitted to the department; or

   (4) That the applicant is a person with a disability. In this rule, “person with a disability” means that, because of a disability or impairment, the applicant is unable to walk in excess of 200 feet unassisted or cannot walk without causing serious detriment or injury to the applicant’s health.

b. “Demonstrates to the satisfaction of the department” means that the department has received written proof that a hardship exists. An applicant who attends a public school shall submit written proof of hardship signed by the applicant’s parent, custodian or guardian and by the superintendent, the chairperson of the school board, or the principal, if authorized by the superintendent, of the applicant’s school or school district of residence. An applicant who attends an accredited nonpublic school shall submit written proof of hardship signed by the applicant’s parent, custodian or guardian and by either an authority in charge of the accredited nonpublic school or a duly authorized representative of the authority, or by the superintendent, the chairperson of the school board, or the principal, if authorized by the superintendent, of the applicant’s school district of residence.

602.26(4) Multiple residences.

a. An applicant whose parents are divorced or separated and who as a result of shared custody maintains more than one residence may be authorized to operate a motor vehicle from either residence during the times and for the purposes set forth in Iowa Code section 321.194 if one of the following applies:
(1) If the applicant attends a public school, the statement of necessity provided to the department certifies that a need exists to drive from each residence, that the school of enrollment identified in the statement of necessity meets the geographic requirements for an applicant attending a public school set forth in Iowa Code section 321.194 as determined by the primary residence identified in the statement of necessity, and that the secondary residence identified in the statement of necessity is either within the school district that includes the applicant’s school of enrollment or within an Iowa school district contiguous to the applicant’s school of enrollment.

(2) If the applicant attends an accredited nonpublic school, the statement of necessity provided to the department certifies that a need exists to drive from each residence, that the school of enrollment identified in the statement of necessity meets the geographic requirements for an applicant attending an accredited nonpublic school set forth in Iowa Code section 321.194 as determined by the primary residence identified in the statement of necessity, and that the secondary residence identified in the statement of necessity is no more than 25 miles driving distance from the school of enrollment.

b. The fact that either residence is less than one mile from the applicant’s school of enrollment shall not preclude travel to and from each residence at the times and for the purposes set forth in Iowa Code section 321.194 provided that need is otherwise demonstrated.

c. A minor’s school license approved for travel to and from two residences for the purposes set forth in Iowa Code section 321.194 shall not be valid for travel directly between each residence unless the licensee is accompanied in accordance with Iowa Code section 321.180B(1).

d. The primary residential address listed in the statement of necessity shall appear on the face of the license. A minor’s school license approved for travel to and from two residences shall include a “J” restriction on the face of the license, and the secondary address listed in the statement of necessity shall be listed on the reverse side of the license as part of the “J” restriction, with the following notation: “Also valid to drive to and from [secondary residential address] in compliance with 321.194.”

This rule is intended to implement Iowa Code sections 321.177, 321.180B, 321.189, 321.194 and 321.196.

[ARC 2644C, IAB 8/3/16, effective 9/7/16; ARC 4271C, IAB 1/30/19, effective 3/6/19]

761—602.27 to 602.29 Reserved.

761—602.30(321) Special instruction permit. Rescinded IAB 1/8/92, effective 2/12/92.

[Filed 1/20/88, Notice 12/2/87—published 2/10/88, effective 3/16/88]
[Filed emergency 6/29/89—published 7/26/89, effective 7/31/89]
[Filed 9/21/89, Notice 7/26/89—published 10/18/89, effective 11/22/89]
[Filed 11/1/89, Notice 7/26/89—published 11/29/89, effective 1/3/90]
[Filed emergency 11/30/89—published 12/27/89, effective 12/1/89]
[Filed emergency 6/7/90—published 6/27/90, effective 7/1/90]
[Filed 12/18/91, Notice 11/13/91—published 1/8/92, effective 2/12/92]
[Filed 10/30/96, Notice 9/25/96—published 11/20/96, effective 12/25/96]
[Filed emergency 7/20/00 after Notice 6/14/00—published 8/9/00, effective 7/24/00]
[Filed 6/19/02, Notice 4/17/02—published 7/10/02, effective 8/14/02]
[Filed 10/11/06, Notice 8/30/06—published 11/8/06, effective 12/13/06]
[Filed ARC 7902B (Notice ARC 7721B, IAB 4/22/09), IAB 7/1/09, effective 8/5/09]
[Filed ARC 1714C (Notice ARC 1601C, IAB 9/3/14), IAB 11/12/14, effective 12/17/14]
[Filed Emergency ARC 2071C, IAB 8/5/15, effective 7/14/15]
[Filed ARC 2337C (Notice ARC 2070C, IAB 8/5/15), IAB 1/6/16, effective 2/10/16]
[Filed ARC 2644C (Notice ARC 2544C, IAB 5/25/16), IAB 8/3/16, effective 9/7/16]
[Filed ARC 2985C (Notice ARC 2908C, IAB 1/18/17), IAB 3/15/17, effective 4/19/17]
[Filed ARC 4271C (Notice ARC 4161C, IAB 12/5/18), IAB 1/30/19, effective 3/6/19]
[Filed ARC 4586C (Notice ARC 4476C, IAB 6/5/19), IAB 7/31/19, effective 9/4/19]

1 Effective date delayed 70 days by the Administrative Rules Review Committee at its March 9, 1988, meeting. Delay lifted by ARRC, April 21, 1988.
CHAPTER 604
LICENSE EXAMINATION

[Prior to 6/3/87, see Transportation Department[820]—(07,C) rules 13.3 and 13.17]

761—604.1(321) Authority and scope.

604.1(1) The department is authorized to determine by examination an applicant’s ability to operate motor vehicles safely upon the highways and to issue all driver’s licenses.

604.1(2) This chapter of rules shall apply to the examination for all driver’s licenses. Information on the additional examination procedures and requirements for a commercial driver’s license or commercial learner’s permit is given in 761—Chapter 607.

This rule is intended to implement Iowa Code sections 321.2, 321.3, 321.13, 321.177, and 321.186. [ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

761—604.2(321) Definitions.

“Binocular field of vision” is the sum of the temporal measurements or the sum of the nasal measurements.

“Monocular field of vision” is the sum of the temporal measurement and the nasal measurement for one eye.

“Representative vehicle” is a vehicle which is characteristic of and requires operating skills comparable to those vehicles that may legally be operated under the class of license or endorsement desired.

This rule is intended to implement Iowa Code sections 321.174 and 321.186. [ARC 9991B, IAB 2/8/12, effective 3/14/12]

761—604.3(17A) Information and forms.

604.3(1) Applications, forms, and information about driver’s license examinations are available at any driver’s license examination station. Assistance is also available from the office of driver services at the address in 761—600.2(17A).

604.3(2) The “Iowa Driver Manual” and the “Iowa Motorcycle Operator Manual” are also available from the department.

This rule is intended to implement Iowa Code section 17A.3.

761—604.4 to 604.6 Reserved.

761—604.7(321) Examination.

604.7(1) An examination shall include:

a. A vision screening if the person has not filed a vision report.

b. A knowledge test of Iowa traffic laws and highway signs.

c. A driving test of the person’s ability to operate a motor vehicle.

604.7(2) The examination required for a driver’s license depends upon the class of license requested, applicable endorsements, and the qualifications of the applicant.

This rule is intended to implement Iowa Code sections 321.186 and 321.186A.

761—604.8 and 604.9 Reserved.

761—604.10(321) Vision screening.

604.10(1) Requirement. Vision screening or a vision report is required of an applicant for a driver’s license.

604.10(2) Method. At driver’s license examination stations, a vision screening instrument shall be used to screen the applicant’s vision. An applicant who has corrective lenses may be screened with or without the corrective lenses.

604.10(3) Report. A vision report shall be submitted on Form 430032 signed by a licensed vision specialist and shall report the person’s visual acuity level and field of vision as measured within 30 days prior to the date of the application. In lieu of Form 430032, a vision report signed by a licensed vision
specialist on the specialist’s letterhead may be accepted if it contains all the information specified on Form 430032.

604.10(4) Exception for persons renewing electronically. An applicant renewing a driver’s license electronically pursuant to 761—subrule 605.25(7) is not required to complete a vision screen or submit a vision report to complete the renewal. This subrule does not preclude the department from requiring a vision screen or vision report of a person who has renewed a driver’s license electronically when the department has reason to believe that the person is not capable of operating a motor vehicle safely.

This rule is intended to implement Iowa Code sections 321.186, 321.186A and 321.196 as amended by 2013 Iowa Acts, House File 355, section 1.

[ARC 9991B, IAB 2/8/12, effective 3/14/12; ARC 0895C, IAB 8/7/13, effective 7/9/13; ARC 1073C, IAB 10/2/13, effective 11/6/13]

761—604.11(321) Vision standards. The visual acuity and field of vision standards for licensing and the applicable restrictions are as follows.

604.11(1) Visual acuity standards.

a. When the applicant is screened without corrective lenses. If the visual acuity is 20/40 or better with both eyes or with the better eye, no restriction will be imposed. If the visual acuity is less than 20/40 but at least 20/70 with both eyes or with the better eye, the applicant shall be restricted from driving when headlights are required.

b. When the applicant is screened with corrective lenses. If the visual acuity is 20/40 or better with both eyes or with the better eye, the applicant shall be required to wear corrective lenses. If the visual acuity is less than 20/40 but at least 20/70 with both eyes or with the better eye, the applicant shall be required to wear corrective lenses and shall be restricted from driving when headlights are required.

c. Other standards. If the visual acuity in the left eye is less than 20/100, the applicant shall be restricted to driving a vehicle with both left and right outside rearview mirrors. However, if the applicant has a visual acuity of 20/40 in the right eye and less than 20/100 in the left eye with corrective lenses and has corrective lenses that improve the vision in the left eye to better than 20/100, the applicant shall have the option of being restricted to driving with corrective lenses or driving a vehicle with both left and right outside rearview mirrors.

604.11(2) Field of vision standards.

a. If the binocular field of vision is at least 140 degrees, no restriction will be imposed.

b. If the binocular field of vision is less than 140 degrees but at least 110 degrees, or one eye has a monocular field of vision of at least 100 degrees, the applicant shall be restricted to driving a vehicle with both left and right outside rearview mirrors.

This rule is intended to implement Iowa Code sections 321.186, 321.193, and 321.196.

[ARC 9991B, IAB 2/8/12, effective 3/14/12]

761—604.12(321) Vision referrals.

604.12(1) Referral.

a. If an applicant on first screening cannot attain 20/40 but can attain 20/70 with at least one eye, the department shall not issue a license to the applicant. Instead, the department shall advise the applicant to consult a licensed vision specialist.

b. A vision report, pursuant to subrule 604.10(3), shall be required before the department will reconsider licensing.

604.12(2) License.

a. The department shall affix a sticker to the applicant’s license stating: “Renewal or license issuance denied due to vision.”

b. If the applicant’s license is valid for less than 30 days, the department may issue a temporary driving permit with restrictions appropriate to the applicant’s visual acuity level and field of vision. The temporary driving permit is valid for not more than 30 days from the end of the current license validity.

604.12(3) Report. If the vision report recommends a restriction, the department shall issue a restricted license even though it would not be required by departmental standards.
604.12(4) Applicant refusal. If an applicant refuses to consult a licensed vision specialist, the department shall issue or deny the license based on the results achieved on the vision screening.

This rule is intended to implement Iowa Code sections 321.181, 321.186, 321.186A, 321.193 and 321.196.

761—604.13(321) Vision screening results.

604.13(1) Two-year license. An applicant who cannot attain a visual acuity of 20/40 with both eyes or with the better eye shall be issued a two-year license. This restriction may be waived by the department when a vision report pursuant to subrule 604.10(3) certifies that the vision has stabilized and is not expected to deteriorate.

604.13(2) License denied.

a. An applicant who cannot attain a visual acuity of 20/70 with both eyes or with the better eye shall not be licensed, subject to discretionary issuance under subrule 604.13(4).

b. If the applicant’s binocular field of vision is less than 110 degrees, or the monocular field of vision is less than 100 degrees, the applicant shall not be licensed, subject to discretionary issuance under subrule 604.13(4).

604.13(3) Reapplication. An applicant who cannot meet the vision standards in subrule 604.13(2) may reapply when the vision improves and meets the vision standards. If a suspension or denial notice was served, reapplication must be made to the office of driver services at the address in 761—600.2(17A), and not at a driver’s license examination station.

604.13(4) Discretionary issuance.

a. An applicant whose license is restricted under rule 761—604.11(321) or who cannot meet the vision standards in subrule 604.13(2) may submit a written request for review by an informal settlement officer.

b. Based upon consideration of the applicant’s vision screening results or vision report, driving test and driving record, the written recommendation of the applicant’s licensed vision specialist, and traffic conditions in the vicinity of the applicant’s residence, the officer may recommend issuing a license with restrictions suitable to the applicant’s capabilities. However:

(1) An applicant who cannot attain a visual acuity of 20/100 with both eyes or with the better eye may be considered for licensing only after recommendation by the medical advisory board.

(2) An applicant who cannot attain a visual acuity of 20/199 with both eyes or with the better eye shall not be licensed.

(3) If an applicant’s binocular field of vision or monocular field of vision is less than 75 degrees, the applicant may be considered for licensing only after recommendation by the medical advisory board.

(4) An applicant who cannot attain a binocular or monocular field of vision of 21 degrees shall not be licensed.

c. The officer’s recommendation denying discretionary issuance or regarding the extent and nature of restrictions is subject to reversal or modification upon review or appeal only if it is clearly characterized by an abuse of discretion.

This rule is intended to implement Iowa Code sections 321.186, 321.186A, 321.193 and 321.196.

[ARC 9991B, IAB 2/8/12, effective 3/14/12]

761—604.14 to 604.19 Reserved.

761—604.20(321) Knowledge test.

604.20(1) Written test. A knowledge test is a written test to determine an applicant’s ability to read and understand Iowa traffic laws and the highway signs that regulate, warn, and direct traffic. A test may be revised at any time but each test states the minimum passing score.

604.20(2) Three types of tests. There are three types of knowledge tests: an operator’s test, a chauffeur’s test, and a motorcycle test. The requirement for a license depends upon the class of license desired, applicable endorsements, and the qualifications of the applicant.
**604.20(3) Oral test.** An applicant who is unable to read or understand a written test may request an oral test. The oral test may be administered by an examiner or by an automated testing device.

**604.20(4) Waiver.** Rescinded IAB 1/8/92, effective 2/12/92.

This rule is intended to implement Iowa Code section 321.186.

### 761—604.21(321) Knowledge test requirements and waivers.

**604.21(1) Knowledge test requirements.** The knowledge test requirements are as follows:

a. **Operator’s test.** An operator’s knowledge test is required for all classes of driver’s licenses and all types of special driver’s licenses and permits.

b. **Motorcycle test.** A motorcycle knowledge test is required for all:

   1. Motorcycle instruction permits.
   2. Class M driver’s licenses.
   3. Motorcycle endorsements.

c. **Chauffeur’s test.** A chauffeur’s knowledge test is required for all:

   1. Chauffeur’s instruction permits.
   2. Class D driver’s licenses except those with an endorsement for “passenger vehicle less than 16-passenger design.”

**604.21(2) Knowledge test waivers.** The department may waive a knowledge test listed in subrule 604.21(1) if the applicant meets one of the following qualifications:

a. The applicant has passed the same type of test for another Iowa driver’s license or an equivalent out-of-state license that is still valid.

b. The applicant has a valid, equivalent driver’s license issued by a foreign jurisdiction with which Iowa has a nonbinding reciprocity agreement.

c. The applicant has a military extension and is renewing the applicant’s Iowa driver’s license within six months following separation from active duty.

This rule is intended to implement Iowa Code sections 321.180, 321.180A, 321.180B, 321.186, 321.189, 321.196 and 321.198.

### 761—604.22(321) Knowledge test results.

**604.22(1) Proof of Passing score.** When necessary, the department shall give the applicant a form, valid for 90 days, which certifies that the applicant has passed the knowledge test.

**604.22(2) Retesting.** An applicant who fails a knowledge test may repeat the test at the discretion of the examiner, but at least two hours shall elapse between tests.

This rule is intended to implement Iowa Code section 321.186.

### 761—604.23 to 604.29 Reserved.

### 761—604.30(321) Driving test.** A driving test is a demonstration of an applicant’s ability to exercise ordinary and reasonable control in the operation of a motor vehicle under actual traffic conditions. The test is also called a road test, field test, or driving demonstration. A motorcycle skill test is an off-street demonstration of an applicant’s ability to control the motorcycle in a set of standard maneuvers, and a motorcycle driving test is an on-street demonstration.

**604.30(1) Vehicle type and safety.**

a. For the driving test, the applicant shall provide a representative vehicle as defined in 761—604.2(321).

b. The examiner or other authorized personnel shall visually inspect the vehicle. If a vehicle is illegal or unsafe, or is not a representative vehicle, the examiner shall refuse to administer the test until corrections are made or an acceptable vehicle is provided.

**604.30(2) Criteria and route.** Form 430024, “Your Driving Test,” explains the criteria for passing the test and shall be given to the applicant before any required test, except a motorcycle skill test. The applicant shall be directed over one of the routes which have been preselected by the examiner to test driving skills and maneuvers.
604.30(3) Test score. The examiner shall use the standard departmental score sheet and shall enter the test score and the licensing decision in the spaces provided. At the end of the test, the examiner shall explain the test score. The test score result is valid for 90 days.

604.30(4) Retesting. If an applicant fails a driving test, the test may be rescheduled at the discretion of the examiner.

This rule is intended to implement Iowa Code sections 321.174 and 321.186.

[REG 9991B, IAB 2/8/12, effective 3/14/12]

761—604.31(321) Driving test requirements and waivers for noncommercial driver’s licenses.

604.31(1) Driving test requirements. The driving test requirements for noncommercial driver’s licenses are as follows:

a. Instruction permits. A driving test is not required to obtain an instruction permit.

b. Class C driver’s licenses. For a Class C driver’s license other than an instruction permit or a motorized bicycle license, an operator’s driving test in a representative vehicle is required, except that an autocycle as defined in Iowa Code section 321.1 shall not be used for the driving test.

c. Class D driver’s licenses. For a Class D driver’s license, a driving test in a representative vehicle for the endorsement requested, as set out in 761—subrule 605.7(3), is required.

d. Class M driver’s licenses and motorcycle endorsements. The driving test for a Class M driver’s license or motorcycle endorsement consists of two parts: an off-street motorcycle skill test and an on-street driving test.

(1) The off-street motorcycle skill test is required. The on-street motorcycle driving test is also required if the applicant does not have another driver’s license that permits unaccompanied driving. Neither motorcycle test is required for the purposes of operating an autocycle.

(2) A motorcycle shall be used for these tests. If a three-wheeled motorcycle is used, the driver’s license shall be restricted: “Not valid for 2-wheel vehicle.” An autocycle is not considered a motorcycle or a three-wheeled motorcycle for testing purposes.

e. Motorized bicycle licenses. For a motorized bicycle license, an off-street or on-street driving test may be required. A motorized bicycle shall be used for the test.

604.31(2) Driving test waivers. The department may waive a required driving test listed in subrule 604.31(1) if the applicant meets one of the following qualifications:

a. The applicant is applying for the applicant’s first Iowa driver’s license that permits unaccompanied driving following successful completion of the appropriate Iowa-approved course or courses. The appropriate Iowa-approved courses are the following: driver education, other than driver education by a teaching parent under rule 761—634.11(321), for a Class C driver’s license other than motorized bicycle; driver education and motorcycle rider education for a Class M driver’s license or motorcycle endorsement; and motorized bicycle education for a motorized bicycle license. However, if an applicant is under the age of 18, a driving test is required if so requested by the applicant’s parent, guardian, or instructor.

b. The applicant is renewing a Class C, Class D or Class M Iowa driver’s license or endorsement within 14 months after the expiration date.

c. The applicant has passed the same type of driving test for another Iowa driver’s license or endorsement that is still valid or has expired within the past 14 months.

d. The applicant has a military extension and is renewing the applicant’s Iowa driver’s license within six months following separation from active duty.

e. The applicant is applying for a Class C Iowa driver’s license that permits unaccompanied driving and has an equivalent out-of-state license that is valid or has expired within the past year.

f. The applicant is applying for a Class D Iowa driver’s license and has an equivalent out-of-state license that is valid or has expired within the past year.

g. The applicant is applying for a Class M driver’s license or a motorcycle endorsement and has an equivalent out-of-state Class M driver’s license or motorcycle endorsement that is valid or has expired within the past year.
h. The applicant has a valid, equivalent driver’s license issued by a foreign jurisdiction with which Iowa has a nonbinding reciprocity agreement.


[ARC 7902B, IAB 7/1/92, effective 8/5/92; ARC 1612C, IAB 9/3/14, effective 10/8/14; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2985C, IAB 3/15/17, effective 4/19/17; ARC 4586C, IAB 7/31/19, effective 9/4/19]

761—604.32(321) Driving tests requirements. Rescinded IAB 1/8/92, effective 2/12/92.

761—604.33 and 604.34 Reserved.

761—604.35(321) Determination of gross vehicle weight rating. For a vehicle that has no legible manufacturer’s certification label, the applicant may provide documentation of the gross vehicle weight rating, such as a manufacturer’s certificate of origin, a title, a vehicle registration document, or the vehicle identification number information for the vehicle. In the absence of the above documentation, the registered weight of the vehicle shall be presumed to be the gross vehicle weight rating.

This rule is intended to implement Iowa Code section 321.1.

761—604.36 to 604.39 Reserved.

761—604.40(321) Failure to pass examination.

604.40(1) An applicant who fails to pass a required examination or reexamination shall not be licensed.

a. If the applicant does not have a valid Iowa license, the department shall deny the applicant a license.

b. If the applicant has a valid Iowa license, the department shall suspend the license for incapability. However, if the applicant’s license is valid for less than 30 days, the department shall deny further licensing. The department shall serve a notice of suspension or denial.

c. See 761—615.4(321) for further information on denials and 761—615.14(321) for further information on suspensions for incapability.

d. An applicant may contest a denial or suspension in accordance with 761—615.38(321).

604.40(2) Limitations on the hearing and appeal process.

a. After a suspension or denial for failure to pass a required knowledge or driving test, a person who contests the suspension or denial shall be deemed to have exhausted the person’s administrative remedies after three unsuccessful attempts to pass the required test.

b. After the three unsuccessful attempts, no further testing shall be allowed until six months have elapsed from the date of the last test failure, and then only if the applicant demonstrates a significant change or improvement in those physical or mental factors that resulted in the original decision. A request for further testing must be submitted in writing to the office of driver services at the address in rule 761—600.2(17A).

c. Notwithstanding paragraphs “a” and “b” of this subrule, no testing shall occur if the director determines that it is unsafe to allow testing.

This rule is intended to implement Iowa Code chapter 17A and sections 321.177, 321.180A and 321.210.

761—604.41 to 604.44 Reserved.

761—604.45(321) Reinstatement. A person whose license has been suspended or denied for failure to pass a required examination or reexamination shall meet the vision standards for licensing, pass the required knowledge examination(s), and pass the required driving test(s) before an Iowa license will be issued.

This rule is intended to implement Iowa Code sections 321.177 and 321.186.

761—604.46 to 604.49 Reserved.
761—604.50(321) Special reexaminations. The department may require a special reexamination consisting of a vision screening, knowledge test and driving test of any licensee.

604.50(1) The department may require a special reexamination when a licensee has been involved in a fatal motor vehicle accident and the investigating officer’s report of the accident indicates the licensee contributed to the accident.

604.50(2) The department may require a special reexamination when a licensee has been involved in two accidents within a three-year period and the investigating officer’s report of each accident lists one of the following “Driver/Vehicle Related Contributing Circumstances” for the licensee:
   a. Ran traffic signal.
   b. Ran stop sign.
   c. Passing, interfered with other vehicle.
   d. Left of center, not passing.
   e. Failure to yield right-of-way at uncontrolled intersection.
   f. Failure to yield right-of-way from stop sign.
   g. Failure to yield right-of-way from yield sign.
   h. Failure to yield right-of-way making left turn.
   i. Failure to yield right-of-way to pedestrian.
   j. Failure to have control.

604.50(3) The department may require a special reexamination when a licensee has been involved in two accidents within a three-year period and the investigating officers’ reports for both accidents list a driver condition for the licensee of “apparently asleep.”

604.50(4) The department may require a special reexamination when a licensee who is 65 years of age or older has been involved in an accident and information in the investigating officer’s or the person’s own report of the accident indicates the need for reexamination. A circumstance that may indicate a need for reexamination includes, but is not limited to, any one of the following:
   a. The licensee made a left turn that resulted in the accident.
   b. The licensee failed to yield the right-of-way at a stop sign.
   c. The licensee failed to yield the right-of-way at a yield sign.
   d. The licensee failed to yield the right-of-way at an uncontrolled intersection.
   e. The licensee failed to yield the right-of-way at a traffic control signal.
   f. The licensee’s vision may be a contributing factor to a nighttime accident.
   g. The licensee has a physical disability-related license restriction other than “corrective lenses” and the accident involved one of the circumstances listed in paragraphs “a” to “f” above.

604.50(5) The department may require a special reexamination when recommended by a peace officer, a court, or a properly documented citizen’s request. A factor that may indicate a need for reexamination includes, but is not limited to, any one of the following:
   a. Loss of consciousness.
   b. Confusion, disorientation or dementia.
   c. Inability to maintain a vehicle in the proper lane.
   d. Repeatedly ignoring traffic control devices in a nonchase setting.
   e. Inability to interact safely with other vehicles.
   f. Inability to maintain consistent speed when no reaction to other vehicles or pedestrians is required.

This rule is intended to implement Iowa Code sections 321.177, 321.186 and 321.210.

[Filed 7/1/75]
[Filed 12/28/76, Notice 11/3/76—published 1/12/77, effective 2/16/77]
[Filed 8/25/80, Notice 7/9/80—published 9/17/80, effective 10/22/80]
[Filed 1/20/88, Notice 12/2/87—published 2/10/88, effective 3/16/88]
[Filed emergency 11/30/89—published 12/27/89, effective 12/1/89]
[Filed emergency 6/7/90—published 6/27/90, effective 7/1/90]
[Filed 12/18/91, Notice 11/13/91—published 1/8/92, effective 2/12/92]
Effective date of 604.11(2) and 604.13(2) ‘b’ delayed until adjournment of the 1988 Session of the General Assembly pursuant to Iowa Code section 17A.8(9) by the Administrative Rules Review Committee at its June 1987 meeting.
CHAPTER 605
LICENSE ISSUANCE

761—605.1(321) Scope. This chapter of rules applies to the issuance of all Iowa driver’s licenses. Additional information on the issuance of a commercial driver’s license or a commercial learner’s permit is given in 761—Chapter 607.

This rule is intended to implement Iowa Code section 321.174.
[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

761—605.2(321) Definitions. The definitions in Iowa Code section 321.1 and the following definitions apply to this chapter.

“License” means “driver’s license” as defined in Iowa Code section 321.1(20A) unless the context otherwise requires.

“Medical report” means a report from a qualified medical professional attesting to a person’s physical or mental capability to operate a motor vehicle safely. The report should be submitted on Form 430031, “Medical Report.” In lieu of Form 430031, a report signed by a qualified medical professional on the qualified medical professional’s letterhead may be accepted if it contains all the information specified on Form 430031.

“Qualified medical professional” means a person licensed as a physician under Iowa Code chapter 148, a person licensed as an advanced registered nurse practitioner under Iowa Code chapter 152 and licensed with the board of nursing, or a person licensed as a physician assistant under Iowa Code chapter 148C, when practicing within the scope of the person’s professional licensure.

This rule is intended to implement Iowa Code section 321.1.
[ARC 4586C, IAB 7/31/19, effective 9/4/19]

761—605.3(321) Persons exempt.

605.3(1) Persons listed in Iowa Code section 321.176 are exempt from driver’s licensing requirements.

605.3(2) “Nearby” in Iowa Code section 321.176(2) shall mean a distance of not more than two miles.

This rule is intended to implement Iowa Code section 321.176.
[ARC 4586C, IAB 7/31/19, effective 9/4/19]

761—605.4(252J,321) Persons not to be licensed.

605.4(1) The department shall not knowingly issue a license to any person who is ineligible for licensing.

605.4(2) The department shall not knowingly license any person who is unable to operate a motor vehicle safely because of physical or mental disability until that person has submitted a medical report stating that the person is physically and mentally capable of operating a vehicle safely.

605.4(3) The department shall not knowingly license any person who has been specifically adjudged incompetent, pursuant to Iowa Code chapter 229, on or after January 1, 1976, including anyone admitted to a mental health facility prior to that date and not released until after, until the department receives specific adjudication that the person is competent. A medical report stating that the person is physically qualified to operate a motor vehicle safely shall also be required.

605.4(4) The department shall not knowingly license any person who suffers from syncope of any cause, any type of periodic or episodic loss of consciousness, or any paroxysmal disturbances of consciousness, including but not limited to epilepsy, until that person has not had an episode of loss of consciousness or loss of voluntary control for six months, and then only upon receipt of a medical report favorable toward licensing.

a. If a medical report indicates a pattern of only syncope, the department may license without a six-month episode-free period after favorable recommendation by the medical advisory board.

b. If a medical report indicates a pattern of such episodes only when the person is asleep or is sequestered for sleep, the department may license without a six-month episode-free period.
c. If an episode occurs when medications are withdrawn by a qualified medical professional, but the person is episode-free when placed back on medications, the department may license without a six-month episode-free period with a favorable recommendation from a neurologist.

d. If a medical report indicates the person experienced a single nonrecurring episode, the cause has been identified, and the qualified medical professional is not treating the person for the episode and believes it is unlikely to recur, the department may license without the six-month episode-free period with a favorable recommendation from a qualified medical professional.

605.4(5) The department shall not license any person who must wear bioptic telescopic lenses to meet the visual acuity standard required for a license.

605.4(6) When a medical report is required, a license shall be issued only if the report indicates that the person is qualified to operate a motor vehicle safely. The department may submit the report to the medical advisory board for an additional opinion.

605.4(7) When the department receives evidence that an Iowa licensed driver has been adjudged incompetent or is not physically or mentally qualified to operate a motor vehicle safely, the department shall suspend the license for incapability, as explained in rule 761—615.14(321), or shall deny further licensing, as explained in rule 761—615.4(321).

605.4(8) The department shall not knowingly issue a license to a person who is the named individual on a certificate of noncompliance that has been received from the child support recovery unit, until the department receives a withdrawal of the certificate of noncompliance or unless an application has been filed pursuant to Iowa Code section 252J.9.

This rule is intended to implement Iowa Code sections 252J.8, 252J.9, 321.13, 321.177, 321.210, and 321.212.

[ARC 4586C, IAB 7/31/19, effective 9/4/19]

761—605.5(321) Contents of license. In addition to the information specified in Iowa Code section 321.189(2), the following information shall be shown on a driver’s license.

605.5(1) Name. The licensee’s full legal name shall be listed as established according to 761—subrule 601.5(1) and 761—subrule 601.5(5) and shall conform to the requirements of 761—subrule 601.1(2).

605.5(2) Current residential address. The licensee’s current residential address shall be listed as established according to the requirements of 761—subrule 601.5(3).

605.5(3) Physical description. The physical description of the licensee on the face of the driver’s license shall include:

a. The licensee’s eye color using these abbreviations: Blk-black, Blu-blue, Bro-brown, Dic-dichromatic, Gry-gray, Grn-green, Haz-hazel, Pnk-pink and Unk-unknown.

b. The licensee’s height in inches.

605.5(4) Date of birth. The licensee’s date of birth shall be listed as established according to 761—subrule 601.5(1) and 761—subrule 601.5(6).

605.5(5) Sex. The licensee’s sex designation shall be listed as established according to the requirements of 761—subrule 601.5(7).

605.5(6) REAL ID markings.

a. A driver’s license that is issued as a REAL ID license as defined in 761—601.7(321) shall include a security marking as required by 6 CFR 37.17(n).

b. A driver’s license that is not issued as a REAL ID license as defined in 761—601.7(321) may be marked as required by 6 CFR 37.71 and any subsequent guidance issued by the U.S. Department of Homeland Security.

c. A driver’s license issued to a foreign national with temporary lawful status shall include the following statement on the face of the license: “limited term.”

605.5(7) Voluntary markings. Upon the request of the licensee, the department shall indicate on the driver’s license any of the following:

a. The presence of a medical condition.

b. That the licensee is a donor under the uniform anatomical gift law.
c. That the licensee has in effect a medical advance directive.

d. That the licensee is hearing impaired or deaf.

e. That the licensee is a veteran.

(1) To be eligible for a veteran designation, the licensee must be an honorably discharged veteran of the armed forces of the United States, the national guard or reserve forces. A licensee who requests a veteran designation shall submit Form 432035, properly completed by the licensee and a designee of the Iowa department of veterans affairs, or the licensee shall present certification of release or discharge from active duty, DD form 214, to the department indicating that the licensee was honorably discharged from active duty. A licensee who was a member of the national guard or reserve forces and who applies directly to the department must present a DD form 214 which indicates that the licensee was honorably discharged after serving for at least a minimum aggregate (total) of 90 days of active duty service for purposes other than training. A licensee who was a member of the national guard or reserve forces and who has a discharge document other than a DD form 214 must have the licensee’s eligibility for a veteran designation determined by a designee of the Iowa department of veterans affairs and shall apply to the department for a veteran designation by submitting Form 432035, properly completed by the licensee and a designee of the Iowa department of veterans affairs.

(2) The department may consult with and defer to the Iowa department of veterans affairs regarding what constitutes a properly completed DD form 214 and veteran status in general.

(3) If the department denies issuance of a license with a veteran designation upon presentation of the DD form 214 to the department, the licensee may obtain a license with a veteran designation if the licensee submits Form 432035, properly completed by the licensee and a designee of the Iowa department of veterans affairs.

(4) If the department issues a veteran designation in error or as the result of fraud on the part of the licensee, the driver’s license with a veteran designation shall be canceled, and a duplicate license without the designation may be issued to the licensee. There shall be no charge to issue a duplicate license if the license was issued in error, unless the error was the result of fraud on the part of the licensee.

This rule is intended to implement Iowa Code sections 142C.3 and 321.189, the REAL ID Act of 2005 (49 U.S.C. Section 30301 note), and 6 CFR Part 37.

[ARC 0347C, IAB 10/3/12, effective 11/7/12; ARC 1714C, IAB 11/12/14, effective 12/17/14; ARC 2888C, IAB 1/4/17, effective 2/8/17; ARC 4000C, IAB 9/12/18, effective 10/17/18; ARC 4000C, IAB 9/12/18, effective 10/17/18; ARC 4586C, IAB 7/31/19, effective 9/4/19]

761—605.6(321) License class. The driver’s license class shall be coded on the face of the driver’s license using these codes:

- Class A—commercial driver’s license
- Class B—commercial driver’s license
- Class C—commercial driver’s license
- Class D—noncommercial driver’s license
- Class E—noncommercial driver’s license, chauffeur
- Class M—noncommercial driver’s license, motorcycle only

This rule is intended to implement Iowa Code section 321.189.

[ARC 0347C, IAB 10/3/12, effective 11/7/12; ARC 4586C, IAB 7/31/19, effective 9/4/19]

761—605.7(321) Endorsements. The endorsements shall be coded on the face of the driver’s license and explained in text on the back of the driver’s license.

605.7(1) For a commercial driver’s license. The following endorsements may be added to a Class A, B or C commercial driver’s license using these letter codes:

- H—Hazardous material
- P—Passenger
- N—Tank
- X—Hazardous material and tank
- T—Double/triple trailers
- S—School bus
605.7(2) *For a commercial learner’s permit.* The following endorsements are the only endorsements that may be added to a commercial learner’s permit using these letter codes. All other endorsements are prohibited on a commercial learner’s permit.

P—Passenger
N—Tank
S—School bus

605.7(3) *For a Class D driver’s license (chauffeur).* The following endorsements may be added to a Class D driver’s license using these number codes:

1—Truck-tractor semitrailer combination
2—Vehicle with 16,001 pounds gross vehicle weight rating or more. Not valid for truck-tractor semitrailer combination
3—Passenger vehicle less than 16-passenger design

605.7(4) *Motorcycle endorsement.* A motorcycle endorsement may be added to any driver’s license that permits unaccompanied driving, other than a Class M driver’s license or a motorized bicycle license, using the following letter code:

L—Motorcycle

This rule is intended to implement Iowa Code sections 321.180 and 321.189.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 4000C, IAB 9/12/18, effective 10/17/18; ARC 4586C, IAB 7/31/19, effective 9/4/19]

605.8(321) *Restrictions.* Restrictions shall be coded on the face of the driver’s license and explained in text on the back of the driver’s license. For purposes of this rule, “CMV” means commercial motor vehicle.

605.8(1) *For all licenses.* The following restrictions may apply to any driver’s license:

B—Corrective lenses required
C—Mechanical aid (as detailed in the restriction on the back of the card)
D—Prosthetic aid (as detailed in the restriction on the back of the card)
F—Left and right outside rearview mirrors
G—No driving when headlights required
H—Temporary restricted license or permit (work permit)
I—Ignition interlock required
J—Restrictions on the back of card
S—SR required (proof of financial responsibility for the future)
T—Medical report required at renewal
U—Not valid for 2-wheel vehicle
W—Restricted commercial driver’s license (CDL)
Y—Intermediate license

605.8(2) *For a noncommercial driver’s license.* The following restrictions apply only to a noncommercial driver’s license:

8—Special instruction permit
9—Passenger restriction for intermediate license
Q—No interstate or freeway driving

605.8(3) *For a commercial driver’s license.* The following restrictions apply to a commercial driver’s license:

E—No manual transmission equipped CMV
K—Intrastate only
L—No air brake equipped CMV
M—No Class A passenger vehicle
N—No Class A and B passenger vehicle
O—No tractor trailer CMV
V—Medical variance
Z—No full air brake equipped CMV
605.8(4) For a commercial learner’s permit. The following restrictions apply to a commercial learner’s permit.

K—Intrastate only
L—No air brake equipped CMV
M—No Class A passenger vehicle
N—No Class A and B passenger vehicle
P—No passengers in CMV bus
V—Medical variance
X—No cargo in CMV tank vehicle

605.8(5) Special licenses. A numbered restriction will designate a special driver’s license using these codes:

1—Motorcycle instruction permit
2—Noncommercial instruction permit (vehicle less than 16,001 gross vehicle weight rating)
3—Commercial learner’s permit
4—Chauffeur’s instruction permit
5—Motorized bicycle license
6—Minor’s restricted license
7—Minor’s school license

605.8(6) Additional information.

a. Reexamination or report. The department may issue a restriction requiring a person to reappear at a specified time for examination. The department may require a medical report to be submitted. The department shall send Form 430029 as a reminder to appear.

b. Loss of consciousness or voluntary control.

   (1) If a person is licensed pursuant to subrule 605.4(4), the department shall issue the first driver’s license with a restriction stating: “Medical report to be furnished at the end of six months.”

   (2) If this medical report shows that the person has been free of an episode of loss of consciousness or voluntary control since the previous medical report and the report recommends licensing, the department shall issue a duplicate driver’s license with a restriction stating: “Medical report required at renewal.” At each renewal accompanied by a favorable medical report, the department shall issue a two-year driver’s license with the same restriction.

   (3) If the latest medical report indicates the person experienced only a single nonrecurring episode, the cause has been identified, and the qualified medical professional is not treating or has not treated the person for the episode and believes it is unlikely to recur, the department may waive the medical report requirement upon receipt of a favorable recommendation from a qualified medical professional.

   (4) The department may remove the medical report requirement and issue a full-term driver’s license if recommended by a qualified medical professional and if the latest medical information on file with the department indicates the person has not had an episode of loss of consciousness or voluntary control and has not been prescribed medications to control such episodes during the 24-month period immediately preceding application for a license.

   (5) The department may remove the medical report requirement and issue a full-term driver’s license if recommended by a qualified medical professional and if the latest medical information on file with the department indicates the person has not had an episode of loss of consciousness or voluntary control during the 10-year period immediately preceding application for a license.

c. Financial responsibility. When a person is required under Iowa Code chapter 321A to have future proof of financial responsibility on file, the license restriction will read: “SR required.” The license shall be valid only for the operation of motor vehicles covered by the class of license issued and by the proof of financial responsibility filed.

d. Vision restriction. Restrictions relating to vision are addressed in 761—Chapter 604.

[ARC 9991B, IAB 2/8/12, effective 3/14/12; ARC 0661C, IAB 4/3/13, effective 5/8/13; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 4000C, IAB 9/12/18, effective 10/17/18; ARC 4586C, IAB 7/31/19, effective 9/4/19]
License term for temporary foreign national. A driver’s license issued to a person who is a foreign national with temporary lawful status shall be issued only for the length of time the person is authorized to be present as verified by the department, not to exceed two years. However, if the person’s lawful status as verified by the department has no expiration date, the driver’s license shall be issued for a period of no longer than one year.

This rule is intended to implement Iowa Code section 321.196, the REAL ID Act of 2005 (49 U.S.C. Section 30301 note), and 6 CFR Part 37.

Fees for driver’s licenses. Fees for driver’s licenses are specified in Iowa Code section 321.191. A license fee may be paid by cash, check, credit card, debit card or money order. If payment is by check, the following requirements apply:

605.10(1) The check shall be for the exact amount of the fee and shall be payable to: Treasurer, State of Iowa. An exception may be made when a traveler’s check is presented.

605.10(2) One check may be used to pay fees for several persons, such as members of a family or employees of a business firm. One check may pay all fees involved, such as the license fee and the reinstatement fee.

This rule is intended to implement Iowa Code section 321.191.

Duplicate license.

605.11(1) Lost, stolen or destroyed license. To replace a valid license that is lost, stolen or destroyed, the licensee shall provide the licensee’s full legal name, date of birth, and social security number, all of which must be verified by the department, and pay the replacement fee. A licensee subject to 761—paragraph 601.5(2)“b” shall provide the applicant’s U.S. Customs and Immigration Services number, which must be verified by the department. The department may investigate or require additional information as may be reasonably necessary to determine that the licensee’s identity matches the identity of record and shall not issue the replacement license if the licensee’s identity is questionable, cannot be determined, or otherwise does not match the identity of record. If the licensee’s current residential address, name, date of birth, or sex designation has changed since the previous license was issued, the licensee shall comply with subrule 605.11(2).

605.11(2) Voluntary replacement. The department shall issue a duplicate of a valid license to an eligible licensee if the license is surrendered to the department and the replacement fee is paid. Voluntary replacement includes but is not limited to:

a. Replacement of a damaged license.

b. Replacement to change the current residential address on a license. The licensee shall notify the department to establish the current residential address.

c. Replacement to change the name on a license. The licensee shall comply with the requirements of 761—subrule 601.5(5) to establish a name change.

d. Replacement to change the date of birth on a license. The licensee shall comply with the requirements of 761—subrule 601.5(6) to establish a change of date of birth.

e. Replacement to change the sex designation on a license. The licensee shall comply with the requirements of 761—subrule 601.5(7) to establish a change of sex designation.

f. Issuance of a license without the words “under 21” to a licensee who is 21 years of age or older. (If the licensee is under 21 years of age, the words “under 21” will replace the words “under 18.”)

g. Issuance of a license without the words “under 18” to a licensee who is 18 years of age or older.

h. Issuance of a noncommercial driver’s license to an eligible person who has been disqualified from operating a commercial motor vehicle.

i. Replacement of a valid license before its expiration date to obtain a license that may be accepted for federal identification purposes under 6 CFR Part 37 (a REAL ID license). The licensee shall comply with the requirements of 761—601.5(321) to obtain a REAL ID license.

j. Replacement to add a veteran designation to the license. To be eligible for a veteran designation, the licensee must comply with the requirements of paragraph 605.5(7)“e.”
605.11(3) Fee. The fee to replace a license is $10.

This rule is intended to implement Iowa Code sections 321.13, 321.189, 321.195 and 321.208, the REAL ID Act of 2005 (49 U.S.C. Section 30301 note), and 6 CFR Part 37.

605.12(321) Address changes.

605.12(1) A licensee shall notify the department of a change in the licensee’s mailing address within 30 days of the change. Notice shall be given by:

a. Submitting the address change in writing to Driver and Identification Services, Iowa Department of Transportation, P.O. Box 9204, Des Moines, Iowa 50306-9204; or

b. Completing the address change on the department’s website at www.iowadot.gov or at a driver’s license kiosk; or

c. Appearing in person to change the mailing address at any driver’s license service center.

605.12(2) Parents or legal guardians may provide written notice of a mailing address change on behalf of their minor children.

605.12(3) The department may use U.S. Postal Service address information to update its address records.

This rule is intended to implement Iowa Code sections 321.182 and 321.184.

605.13 and 605.14 Reserved.

605.15(321) License extension.

605.15(1) Six-month extension. An Iowa resident may apply for a six-month extension of a license if the resident:

a. Has a valid license,

b. Is eligible for further licensing, and

c. Is temporarily absent from Iowa or is temporarily incapacitated at the time for renewal.

605.15(2) Procedure. The licensee shall apply for an extension by submitting Form 430027 to the department. The form may be obtained from and submitted to a driver’s license service center. The licensee may also apply by letter to the address in paragraph 605.12(1) “a.”

a. A six-month extension shall be added to the expiration date on the license. When the licensee appears to renew the license, the expiration date of the renewed license will be computed from the expiration date of the original license, notwithstanding the extension.

b. The department shall allow only two six-month extensions.

This rule is intended to implement Iowa Code section 321.196.

605.16(321) Military extension.

605.16(1) Form 430028. A person who qualifies for a military extension of a valid license should request Form 430028 from the department and carry it with the license for verification to peace officers. Form 430028 explains the provisions of Iowa Code section 321.198 regarding military extensions.

605.16(2) Request for retention of record. A person with a military extension may request that the department retain the record of license issuance for the duration of the extension or reenter the record if it has been removed from department records. The request may be made by letter or by using Form 430081. The letter or Form 430081 shall be signed by the person’s commanding officer to verify the military service and shall be submitted to the department at the address in paragraph 605.12(1) “a.”

605.16(3) Renewal of license after military extension. When an applicant renews a license after a military extension, the department may require the applicant to provide documentation of both the military service and the date of separation from military service.
605.16(4) Reinstatement after sanction. A person with a military extension whose license has been canceled, suspended or revoked shall comply with the requirements of 761—615.40(321) to reinstate the license.

This rule is intended to implement Iowa Code section 321.198.

[ARC 4000C, IAB 9/12/18, effective 10/17/18]

761—605.17 to 605.19 Reserved.

761—605.20(321) Fee adjustment for upgrading license. The fee for upgrading a driver’s license shall be computed on a full-year basis. The fee is charged for each year or part of a year between the date of the change and the expiration date on the license.

605.20(1) The fee to upgrade a driver’s license from one class to another is determined by computing the difference between the current license fee and the new license fee as follows:

a. Converting noncommercial Class C to Class D—$4 per year of new license validity.

b. Converting Class M to Class D with a motorcycle endorsement—$4 per year of new license validity.

c. Converting Class M to noncommercial Class C with a motorcycle endorsement—$2 one-time fee.

605.20(2) The fee to add a privilege to a driver’s license is computed per year of new license validity as follows:

<table>
<thead>
<tr>
<th>License Type</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Noncommercial Class C</td>
<td>$4 per year</td>
</tr>
<tr>
<td>(full privileges from a restricted Class C)</td>
<td></td>
</tr>
<tr>
<td>Motorized bicycle</td>
<td>$4 per year</td>
</tr>
<tr>
<td>Minor’s restricted license</td>
<td>$4 per year</td>
</tr>
<tr>
<td>Minor’s school license</td>
<td>$4 per year</td>
</tr>
<tr>
<td>Motorcycle instruction permit</td>
<td>$2 per year</td>
</tr>
<tr>
<td>Motorcycle endorsement</td>
<td>$2 per year</td>
</tr>
</tbody>
</table>

This rule is intended to implement Iowa Code sections 321.189 and 321.191.

[ARC 1714C, IAB 11/12/14, effective 12/17/14]

761—605.21 to 605.24 Reserved.

761—605.25(321) License renewal.

605.25(1) A licensee who wishes to renew a driver’s license shall apply to the department and, if required, pass the appropriate examination.

605.25(2) A valid license may be renewed within 180 days before the expiration date. If this is impractical, the department for good cause may renew a license earlier.

605.25(3) A valid license may be renewed within 60 days after the expiration date, unless otherwise specified.

605.25(4) If the licensee’s current residential address, name, date of birth, or sex designation has changed since the previous license was issued, the licensee shall comply with the following:

a. Current residential address. The licensee shall notify the department to establish the current residential address.

b. Name. The licensee shall comply with the requirements of 761—subrule 601.5(5) to establish a name change.

c. Date of birth. The licensee shall comply with the requirements of 761—subrule 601.5(6) to establish a change of date of birth.

d. Sex designation. The licensee shall comply with the requirements of 761—subrule 601.5(7) to establish a change of sex designation.

605.25(5) A licensee who has not previously been issued a license that may be accepted for federal identification purposes under 6 CFR Part 37 (a REAL ID license) and wishes to obtain a REAL ID license
upon renewal must comply with the requirements of 761—601.5(321) to obtain a REAL ID license upon renewal.

605.25(6) A licensee who is a foreign national with temporary lawful status must provide documentation of lawful status as required by 761—subrule 601.5(4) at each renewal.

605.25(7) The department may determine means or methods for electronic renewal of a driver’s license.

a. An applicant who meets the following criteria may apply for electronic renewal:

(1) The applicant must be at least 18 years of age but not yet 70 years of age.
(2) The applicant completed a satisfactory vision screen or submitted a satisfactory vision report under 761—subrules 604.10(1) to 604.10(3) and updated the applicant’s photo at the applicant’s last issuance or renewal.
(3) The applicant’s driver’s license has not been expired for more than one year.
(4) The department’s records show the applicant is a U.S. citizen.
(5) The applicant’s driver’s license is not marked “valid without photo.”
(6) The applicant is not seeking to change any of the following information as it appears on the applicant’s driver’s license:
   1. Name.
   2. Date of birth.
   3. Sex.
   7. The applicant’s driver’s license is a Class C noncommercial driver’s license, a Class D noncommercial driver’s license (chauffeur), or Class M noncommercial driver’s license (motorcycle) that is not a special license or permit, a temporary restricted license, or a two-year license.
(8) The applicant is not subject to a pending request for reexamination.
(9) The applicant does not wish to change any of the following:
   1. Class of license.
   2. License endorsements.
   3. License restrictions.
(10) The applicant is not subject to any of the following restrictions:
   G—No driving when headlights required
   J—Restrictions on the back of card
   T—Medical report required at renewal
   S—Special instruction permit
   Q—No interstate or freeway driving
   R—Maximum speed of 35 mph
b. Notwithstanding any other provision of this subrule to the contrary, the department may accept an electronic renewal application if the license contains a single “J” restriction accompanied by a “7,” “I” or “Y” restriction.

c. The department reserves the right to deny electronic renewal and to require the applicant to personally apply for renewal at a driver’s license service center if it appears to the department that the applicant may have a physical or mental condition that may impair the applicant’s ability to safely operate a motor vehicle, even if the applicant otherwise meets the criteria in 605.25(7)”a.”

d. An applicant who has not previously been issued a driver’s license that is compliant with the REAL ID Act of 2005, 49 U.S.C. Section 30301 note, as further defined in 6 CFR Part 37 (a REAL ID license) may not request a REAL ID driver’s license by electronic renewal.

This rule is intended to implement Iowa Code sections 321.186 and 321.196, the REAL ID Act of 2005 (49 U.S.C. Section 30301 note), and 6 CFR Part 37.

[ARC 0347C, IAB 10/3/12, effective 11/7/12; ARC 0895C, IAB 8/7/13, effective 7/9/13; ARC 1073C, IAB 10/2/13, effective 11/6/13; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 4000C, IAB 9/12/18, effective 10/17/18]

761—605.26(321) License renewal by mail. Rescinded IAB 3/20/02, effective 4/24/02.

[Filed emergency 6/7/90—published 6/27/90, effective 7/1/90]

[Filed emergency 10/24/90—published 11/14/90, effective 10/24/90]
Effective date of December 29, 1993, for 761—605.26(2)“a” and “d.” delayed 70 days by the Administrative Rules Review Committee at its meeting held December 15, 1993; delay lifted by this Committee on January 5, 1994, effective January 6, 1994.
CHAPTER 607
COMMERCIAL DRIVER LICENSING

761—607.1(321) Scope. This chapter applies to licensing persons for the operation of commercial motor vehicles. Unless otherwise stated, the provisions of this chapter are in addition to other motor vehicle licensing rules.

This rule is intended to implement Iowa Code chapter 321.

761—607.2(17A) Information.

607.2(1) Information and location. Applications, forms and information about the commercial driver’s license (CDL) are available at any driver’s license examination station. Assistance is also available by mail from Driver and Identification Services, Iowa Department of Transportation, P.O. Box 9204, Des Moines, Iowa 50306-9204; in person at 6310 SE Convenience Blvd., Ankeny, Iowa; by telephone at (515)244-8725; by facsimile at (515)239-1837; or on the department’s website at www.iowadot.gov.

607.2(2) Manual. A copy of a study manual for the commercial driver’s license tests is available upon request at any driver’s license examination station and on the department’s website.

This rule is intended to implement Iowa Code section 17A.3.

[ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 3689C, IAB 3/14/18, effective 4/18/18]

761—607.3(321) Definitions. The definitions in Iowa Code section 321.1 apply to this chapter of rules.

In addition, the following definitions are adopted:

“Air brake system” means a system that uses air as a medium for transmitting pressure or force from the driver’s control to the service brake. “Air brake system” shall include any braking system operating fully or partially on the air brake principle.

“Air over hydraulic brakes” means any braking system operating partially on the air brake and partially on the hydraulic brake principle.

“Automatic transmission” means any transmission other than a manual transmission.

“CDLIS” means “commercial driver’s license information system” as defined in Iowa Code section 321.1.

“Commercial driver’s license downgrade” or “CDL downgrade” means either:
1. The driver changes the driver’s self-certification of type of driving from non-excepted interstate to excepted interstate, non-excepted intrastate, or excepted intrastate driving, or
2. The department removed the CDL privilege from the driver’s license.

“Commercial motor vehicle” or “CMV” as defined in Iowa Code section 321.1 does not include a motor vehicle designed as off-road equipment rather than as a motor truck, such as a forklift, motor grader, scraper, tractor, trencher or similar industrial-type equipment. “Commercial motor vehicle” also does not include self-propelled implements of husbandry described in Iowa Code subsection 321.1(32).

“Controlled substance” as used in Iowa Code section 321.208 means a substance defined in Iowa Code section 124.101.

“Hazardous materials” means any material that has been designated as hazardous under 49 U.S.C. Section 5103 and is required to be placarded under 49 CFR Part 172, Subpart F, or any quantity of a material listed as a select agent or toxin in 42 CFR Part 73.

“Manual transmission” means a transmission utilizing a driver-operated clutch that is activated by a pedal or lever and a gear-shift mechanism operated either by hand or by foot. All other transmissions, whether semi-automatic or automatic, will be considered automatic.

“Medical examiner” means a person who is licensed, certified or registered, in accordance with applicable state laws and regulations, to perform physical examinations. The term includes but is not limited to doctors of medicine, doctors of osteopathy, physician assistants, advanced registered nurse practitioners, and doctors of chiropractic.

“Medical examiner’s certificate” means a certificate completed and signed by a medical examiner under the provisions of 49 CFR Section 391.43.
“Medical variance” means a driver has received one of the following from the Federal Motor Carrier Safety Administration that allows the driver to be issued a medical certificate:

1. An exemption letter permitting operation of a commercial motor vehicle pursuant to 49 CFR Part 381, Subpart C, or 49 CFR Section 391.62, or 49 CFR Section 391.64.
2. A skill performance evaluation certificate permitting operation of a commercial motor vehicle pursuant to 49 CFR Section 391.49.

“Passenger vehicle” means either of the following:

1. A motor vehicle designed to transport 16 or more persons including the operator.
2. A motor vehicle of a size and design to transport 16 or more persons including the operator which is redesigned or modified to transport fewer than 16 persons with disabilities. The size of a redesigned or modified vehicle shall be any such vehicle with a gross vehicle weight rating of 10,001 or more pounds.

“School bus” means a commercial motor vehicle used to transport pre-primary, primary, or secondary school students from home to school, from school to home, or to and from school-sponsored events. “School bus” does not include a bus used as a common carrier.

“Self-certification” means a written certification of which category of type of driving an applicant for a commercial driver’s license engages in or intends to engage in, from the following categories:

1. Non-excepted interstate. The person certifies that the person operates or expects to operate in interstate commerce, is both subject to and meets the qualification requirements under 49 CFR Part 391, and is required to obtain a medical examiner’s certificate by 49 CFR Section 391.45.
2. Excepted interstate. The person certifies that the person operates or expects to operate in interstate commerce, but engages exclusively in transportation or operations excepted under 49 CFR Section 390.3(f), 391.2, 391.68 or 398.3 from all or parts of the qualification requirements of 49 CFR Part 391, and is therefore not required to obtain a medical examiner’s certificate by 49 CFR Section 391.45.
3. Non-excepted intrastate. The person certifies that the person operates only in intrastate commerce and is subject to state driver qualification requirements.
4. Exempted intrastate. The person certifies that the person operates only in intrastate commerce, but engages exclusively in transportation or operations excepted from all or parts of the state driver qualification requirements as set forth in Iowa Code section 321.449.

“State,” as used in this chapter and in “another state” in Iowa Code subsection 321.174(2), “former state of residence” in Iowa Code subsection 321.188(5), or “any state” in Iowa Code subsection 321.208(1), means one of the United States or the District of Columbia unless the context means the state of Iowa.

This rule is intended to implement Iowa Code sections 321.1, 321.174, 321.188, 321.191, 321.193, 321.207 and 321.208.

[ARC 7902B, IAB 7/1/99, effective 8/5/99; ARC 9954B, IAB 1/11/12, effective 1/30/12; ARC 0031C, IAB 3/7/12, effective 4/1/12; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

761—607.4 and 607.5 Reserved.

761—607.6(321) Exemptions.

607.6(1) Persons exempt. A person listed in Iowa Code section 321.176A is exempt from commercial driver licensing requirements.

607.6(2) Exempt until April 1, 1992. Rescinded IAB 6/23/93, effective 7/28/93.

This rule is intended to implement Iowa Code sections 321.1 and 321.176A.

761—607.7(321) Records. The operating record of a person who has been issued a commercial driver’s license or a commercial learner’s permit or a person who has been disqualified from operating a commercial motor vehicle shall be maintained as provided in the department’s “Record Management Manual” adopted in 761—Chapter 4.

This rule is intended to implement Iowa Code sections 22.11, 321.12 and 321.199.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]
761—607.8 and 607.9 Reserved.

761—607.10(321) Adoption of federal regulations.

607.10(1) Code of Federal Regulations. The department’s administration of commercial driver’s licenses shall be in compliance with the state procedures set forth in 49 CFR Section 383.73, and this chapter shall be construed to that effect. The department adopts the following portions of the Code of Federal Regulations which are referenced throughout this chapter of rules:

a. 49 CFR Section 391.11 as adopted in 761—Chapter 520.

b. 49 CFR Section 392.5 as adopted in 761—Chapter 520.

c. The following portions of 49 CFR Part 383 (October 1, 2018):

(1) Section 383.51, Disqualification of drivers.

(2) Subpart E—Testing and Licensing Procedures.

(3) Subpart G—Required Knowledge and Skills.

(4) Subpart H—Tests.

607.10(2) Copies of regulations. Copies of the federal regulations may be reviewed at the state law library or through the Internet at www.fmcsa.dot.gov.

This rule is intended to implement Iowa Code sections 321.187, 321.188, 321.207, 321.208 and 321.208A.

[ARC 7902B, IAB 7/1/09, effective 8/5/09; ARC 9954B, IAB 1/1/12, effective 1/30/12; ARC 0031C, IAB 3/7/12, effective 4/11/12; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 2986C, IAB 3/15/17, effective 4/19/17; ARC 3840C, IAB 6/6/18, effective 7/11/18; ARC 4401C, IAB 4/10/19, effective 5/15/19]

761—607.11 to 607.14 Reserved.

761—607.15(321) Application. An applicant for a commercial driver’s license shall comply with the requirements of Iowa Code sections 321.180(2)”e,” 321.182 and 321.188, and 761—Chapter 601, and must provide the proofs of citizenship or lawful permanent residence and state of domicile required by 49 CFR Section 383.71. If the applicant is domiciled in a foreign jurisdiction and applying for a nondomiciled commercial driver’s license, the applicant must provide a document required by 49 CFR Section 383.71(f).

This rule is intended to implement Iowa Code sections 321.180, 321.182 and 321.188.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

761—607.16(321) Commercial driver’s license (CDL).

607.16(1) Classes. The department may issue a commercial driver’s license only as a Class A, B or C driver’s license. The license class identifies the types of vehicles that may be operated. A commercial driver’s license may have endorsements which authorize additional vehicle operations or restrictions which limit vehicle operations.

607.16(2) Validity.

a. A Class A commercial driver’s license allows a person to operate a combination of commercial motor vehicles as specified in Iowa Code paragraph 321.189(1)”a.” With the required endorsements and subject to the applicable restrictions, a Class A commercial driver’s license is valid to operate any vehicle.

b. A Class B commercial driver’s license allows a person to operate a commercial motor vehicle as specified in Iowa Code paragraph 321.189(1)”b.” With the required endorsements and subject to the applicable restrictions, a Class B commercial driver’s license is valid to operate any vehicle except a truck-tractor semitrailer combination as a chauffeur (Class D) or a vehicle requiring a Class A commercial driver’s license.

c. A Class C commercial driver’s license allows a person to operate a commercial motor vehicle as specified in Iowa Code paragraph 321.189(1)”c.” With the required endorsements and subject to the applicable restrictions, a Class C commercial driver’s license is valid to operate any vehicle except a truck-tractor semitrailer combination as a chauffeur (Class D) or a vehicle requiring a Class A or Class B commercial driver’s license.
d. A commercial driver’s license is valid for operating a motorcycle as a commercial motor vehicle only if the license has a motorcycle endorsement and a hazardous material endorsement. A commercial driver’s license is valid for operating a motorcycle as a noncommercial motor vehicle only if the license has a motorcycle endorsement.

e. A commercial driver’s license valid for eight years shall be issued to a qualified applicant who is at least 18 years of age but not yet 72 years of age. However, the expiration date of the license issued shall not exceed the licensee’s 74th birthday.

f. A commercial driver’s license valid for two years shall be issued to a qualified applicant 72 years of age or older. A two-year license may also be issued, at the discretion of the department, to an applicant whose license is restricted due to vision or other physical disabilities.

g. A commercial driver’s license is valid for 60 days after the expiration date.

h. A person with a commercial driver’s license valid for the vehicle operated is not required to obtain a Class D driver’s license to operate the vehicle as a chauffeur.

607.16(3) Requirements.

a. The minimum age to obtain a commercial driver’s license is 18 years.

b. The applicant shall meet the requirements set forth in rule 761—607.15(321).

607.16(4) Transition from five-year to eight-year licenses. During the period January 1, 2014, to December 31, 2018, the department shall issue qualified applicants otherwise eligible for an eight-year license a five-year, six-year, seven-year, or eight-year license, subject to all applicable limitations for age and ability. The applicable period shall be randomly assigned to the applicant by the department’s computerized issuance system based on a distribution formula intended to spread renewal volumes as equally as practical over the eight-year period beginning January 1, 2019, and ending December 31, 2026.

This rule is intended to implement Iowa Code sections 321.177, 321.182, 321.188, 321.189, and 321.196 and 2013 Iowa Acts, chapter 104, section 2.

[ARC 1714C, IAB 11/12/14, effective 12/17/14; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

761—607.17(321) Endorsements. All endorsements except the hazardous material endorsement continue to be valid without retesting or additional fees when renewing or upgrading a license. The endorsements that authorize additional commercial motor vehicle operations with a commercial driver’s license are:

607.17(1) Hazardous material. A hazardous material endorsement (H) is required to transport hazardous materials. Upon license renewal, retesting and fee payment are required. Retesting and fee payment are also required when an applicant upgrades an Iowa license or transfers a commercial driver’s license from another state unless the applicant provides evidence of passing the endorsement test within the preceding 24 months. A farmer or a person working for a farmer is not subject to the hazardous material endorsement while operating either a pickup or a special truck within 150 air miles of the farmer’s farm to transport supplies to or from the farm.

607.17(2) Passenger vehicle. A passenger vehicle endorsement (P) is required to operate a passenger vehicle as defined in rule 761—607.3(321).

607.17(3) Tank vehicle. A tank vehicle endorsement (N) is required to operate a tank vehicle as defined in Iowa Code section 321.1. A vehicle transporting a tank, regardless of the tank’s capacity, which does not otherwise meet the definition of a commercial motor vehicle in Iowa Code section 321.1 is not a tank vehicle.

607.17(4) Double/triple trailer. A double/triple trailer endorsement (T) is required to operate a commercial motor vehicle with two or more towed trailers when the combination of vehicles meets the criteria for a Class A commercial motor vehicle. Operation of a triple trailer combination vehicle is not permitted in Iowa.

607.17(5) Hazardous material and tank. A combined endorsement (X) authorizes both hazardous material and tank vehicle operations.
607.17(6) School bus. After September 30, 2005, a school bus endorsement (S) is required to operate a school bus as defined in rule 761—607.3(321). An applicant for a school bus endorsement must also qualify for a passenger vehicle endorsement.

607.17(7) Exceptions for towing operations.

a. A driver who tows a vehicle in an emergency “first move” from the site of a vehicle malfunction or accident on a highway to the nearest appropriate repair facility is not required to have the endorsement(s) applicable to the towed vehicle. In any subsequent move, a driver who tows a vehicle from one repair or disposal facility to another is required to have the endorsement(s) applicable to the towed vehicle with one exception: A tow truck driver is not required to have a passenger endorsement to tow a passenger vehicle.

b. The double/triple trailer endorsement is not required to operate a commercial motor vehicle with two or more towed vehicles that are not trailers.

This rule is intended to implement Iowa Code sections 321.1, 321.176A and 321.189.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

761—607.18(321) Restrictions. The restrictions that may limit commercial motor vehicle operation with a commercial driver’s license are listed in 761—subrule 605.8(3) and are explained below:

607.18(1) Air brake. The air brake restriction (L, no air brake equipped CMV) applies to a licensee who either fails the air brake component of the knowledge test or performs the skills test in a vehicle not equipped with air brakes and prohibits the operation of a commercial motor vehicle equipped with an air brake system until the licensee passes the required air brake tests and pays the fee for upgrading the license. Retesting and fee payment are not required when the license is renewed.

607.18(2) Full air brake. The full air brake restriction (Z, no full air brake equipped CMV) applies to a licensee who performs the skills test in a vehicle equipped with air over hydraulic brakes and prohibits the operation of a commercial motor vehicle equipped with any braking system operating fully on the air brake principle until the licensee passes the required air brake tests and pays the fee for upgrading the license. Retesting and fee payment are not required when the license is renewed.

607.18(3) Manual transmission. The manual transmission restriction (E, no manual transmission equipped CMV) applies to a licensee who performs the skills test in a vehicle equipped with automatic transmission and prohibits the operation of a commercial motor vehicle equipped with a manual transmission until the licensee passes the required tests and pays the fee for upgrading the license. Retesting and fee payment are not required when the license is renewed.

607.18(4) Tractor-trailer. The tractor-trailer restriction (O, no tractor trailer CMV) applies to a licensee who performs the skills test in a combination vehicle for a Class A commercial driver’s license with the power unit and towed unit connected with a pintle hook or other non-fifth wheel connection and prohibits operation of a tractor-trailer combination connected by a fifth wheel that requires a Class A commercial driver’s license until the licensee passes the required tests and pays the fee for upgrading the license. Retesting and fee payment are not required when the license is renewed.

607.18(5) Class A passenger vehicle. The Class A passenger vehicle restriction (M, no Class A passenger vehicle) applies to a licensee who applies for a passenger endorsement and performs the skills test in a passenger vehicle that requires a Class B commercial driver’s license and prohibits operation of a passenger vehicle that requires a Class A commercial driver’s license.

607.18(6) Class A and B passenger vehicle. The Class A and B passenger vehicle restriction (N, no Class A and B passenger vehicle) applies to a licensee who applies for a passenger endorsement and performs the skills test in a passenger vehicle that requires a Class C commercial driver’s license and prohibits operation of a passenger vehicle that requires a Class A or Class B commercial driver’s license.

607.18(7) Intrastate only. The intrastate only restriction (K, intrastate only) applies to a licensee who self-certifies to non-excepted intrastate or excepted intrastate driving and prohibits the operation of a commercial motor vehicle in interstate commerce.

607.18(8) Medical variance. The medical variance restriction (V, medical variance) applies to a licensee when the department is notified pursuant to 49 CFR Section 383.73(o)(3) that the driver has
been issued a medical variance and indicates there is information about a medical variance on the CDLIS driver record.

This rule is intended to implement Iowa Code sections 321.189 and 321.191.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 4586C, IAB 7/31/19, effective 9/4/19]

761—607.19 Reserved.

761—607.20(321) Commercial learner’s permit.

607.20(1) Validity.

a. A commercial learner’s permit allows the permit holder to operate a commercial motor vehicle when accompanied as required by Iowa Code section 321.180(2) “d.”

b. A commercial learner’s permit is valid for one year without retaking the general and endorsement knowledge tests required by Iowa Code section 321.188.

c. A commercial learner’s permit is invalid after the expiration date of the underlying commercial or noncommercial driver’s license issued to the permit holder or the expiration date of the permit whichever occurs first.

d. The issuance of a commercial learner’s permit is a precondition to the initial issuance of a commercial driver’s license. The issuance of a commercial learner’s permit is also a precondition to the upgrade of a commercial driver’s license if the upgrade requires a skills test. The holder of a commercial learner’s permit is not eligible to take a required driving skills test for the first 14 days after the permit holder is issued the permit. The 14-day period includes the day the commercial learner’s permit was issued.

EXAMPLE: The commercial learner’s permit is issued on September 1. The earliest date the permit holder would be eligible to take the skills test is September 15.

e. A commercial learner’s permit is not valid for the operation of a vehicle transporting hazardous materials.

607.20(2) Requirements.

a. An applicant for a commercial learner’s permit must hold a valid Class A, B, C, or D driver’s license issued in this state that is not an instruction permit, a special instruction permit, a motorized bicycle license or a temporary restricted license; must be at least 18 years of age; and must meet the requirements to obtain a valid commercial driver’s license, including the requirements set forth in Iowa Code section 321.188. However, the applicant does not have to complete the driving skills tests required for a commercial driver’s license to obtain a commercial learner’s permit.

b. The applicant must successfully pass a general knowledge test that meets the federal standards contained in 49 CFR Part 383, Subparts F, G and H, for the commercial motor vehicle the applicant operates or expects to operate, including any endorsement for which the applicant applies.

607.20(3) Endorsements. A commercial learner’s permit may include the following endorsements. All other endorsements are prohibited on a commercial learner’s permit.

a. An applicant for a passenger endorsement (P) must take and pass the passenger endorsement knowledge test. A commercial learner’s permit holder with a passenger endorsement is prohibited from operating a commercial motor vehicle carrying passengers, other than federal/state auditors and inspectors, test examiners, other trainees, and the commercial driver’s license holder accompanying the permit holder required by Iowa Code section 321.180(2) “d.”

b. An applicant for a school bus endorsement (S) must take and pass the school bus endorsement knowledge test. A commercial learner’s permit holder with a school bus endorsement is prohibited from operating a commercial motor vehicle carrying passengers, other than federal/state auditors and inspectors, test examiners, other trainees, and the commercial driver’s license holder accompanying the permit holder required by Iowa Code section 321.180(2) “d.”

c. An applicant for a tank vehicle endorsement (N) must take and pass the tank vehicle endorsement knowledge test. A commercial learner’s permit holder with a tank vehicle endorsement may only operate an empty tank vehicle and is prohibited from operating any tank vehicle that previously contained hazardous materials that has not been purged of any residue.
607.20(4) Restrictions. A commercial learner’s permit may include the air brake (L), medical variance (V), Class A passenger vehicle (M), Class A and B passenger vehicle (N) and intrastate only (K) restrictions described in rule 761—607.18(321). In addition, a commercial learner’s permit may include the following restrictions that are specific to the commercial learner’s permit:

a. Passenger. The passenger restriction (P, no passengers in CMV bus) applies to a permit holder who has a commercial learner’s permit with a passenger or school bus endorsement and prohibits the operation of a commercial motor vehicle carrying passengers, other than federal/state auditors and inspectors, test examiners, other trainees, and the commercial driver’s license holder accompanying the permit holder required by Iowa Code section 321.180(2) “d.”

b. Cargo. The cargo restriction (X, no cargo in CMV tank vehicle) applies to a permit holder who has a commercial learner’s permit with a tank vehicle endorsement and prohibits the operation of any tank vehicle containing cargo or any tank vehicle that previously contained hazardous materials that has not been purged of any residue.

This rule is intended to implement Iowa Code sections 321.180, 321.186 and 321.188.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 3689C, IAB 3/14/18, effective 4/18/18]

761—607.21 to 607.24 Reserved.

761—607.25(321) Examination for a commercial driver’s license. In addition to the requirements of 761—Chapter 604, an applicant for a commercial driver’s license shall pass the knowledge and skills tests as required in 49 CFR Part 383, Subparts G and H.

This rule is intended to implement Iowa Code section 321.186.

761—607.26(321) Vision screening. An applicant for a commercial driver’s license or commercial learner’s permit must pass a vision screening test administered by the department. The vision standards are given in 761—604.11(321).

This rule is intended to implement Iowa Code sections 321.186 and 321.186A.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

761—607.27(321) Knowledge tests.

607.27(1) General knowledge test. The general knowledge test for a commercial driver’s license is a written test of topics such as vehicle inspection, operation, safety and control in accordance with 49 CFR Section 383.111.

607.27(2) Additional tests. In addition to the general knowledge test for a commercial driver’s license, an additional knowledge test is required for each of the following:

a. Class A license for combination vehicle operation as required in 49 CFR Section 383.111.

b. Hazardous material endorsement as required in 49 CFR Section 383.121. The knowledge test for a hazardous material endorsement shall not be administered orally or in a language other than English.

c. Passenger vehicle endorsement as required in 49 CFR Section 383.117.

d. Tank vehicle endorsement as required in 49 CFR Section 383.119.

e. Double/triple trailer endorsement as required in 49 CFR Section 383.115.

f. School bus endorsement as required in 49 CFR Section 383.123. The applicant must also qualify for a passenger vehicle endorsement.

g. Removal of the air brake restriction as required in 49 CFR Section 383.111.

607.27(3) Test methods. All knowledge tests shall be administered in compliance with 49 CFR Section 383.133(b). All tests other than the hazardous material endorsement test may be administered in written form, verbally, or in automated format and can be administered in a foreign language, provided no interpreter is used in administering the test. A verbal test shall be offered only at specified locations. Information about the locations is available at any driver’s license examination station.

607.27(4) Waiver. A waiver of any knowledge test is permitted only as provided in Iowa Code subsection 321.188(5). The burden of proof of having passed the hazardous material endorsement test within the preceding 24 months rests with the applicant.
607.27(5) Requirement. An applicant must pass the applicable knowledge test(s) before taking the skills test. Passing scores for a knowledge test shall meet the standards contained in 49 CFR Section 383.135(a).

This rule is intended to implement Iowa Code sections 321.186 and 321.188.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

761—607.28(321) Skills test.

607.28(1) Content. The skills test for a commercial driver’s license is a three-part test as required in 49 CFR Part 383, Subparts E, G and H.

607.28(2) Test methods. All skills tests shall be administered in compliance with 49 CFR Section 383.133(c). Interpreters are prohibited during the administration of skills tests. Applicants must be able to understand and respond to verbal commands and instructions in English by a skills test examiner. Neither the applicant nor the examiner may communicate in a language other than English during the skills test.

607.28(3) Order. The skills test must be administered and successfully completed in the following order: pre-trip inspection, basic vehicle control skills, on-road skills. If an applicant fails one segment of the skills test, the applicant cannot continue to the next segment of the test, and scores for the passed segments of the test are only valid during initial issuance of the commercial learner’s permit.

607.28(4) Vehicle. The applicant shall provide a representative vehicle for the skills test. “Representative vehicle” means a commercial motor vehicle that meets the statutory description for the class of license applied for.

a. To obtain a passenger vehicle endorsement applicable to a specific vehicle class, the applicant must take the skills test in a passenger vehicle, as defined in rule 761—607.3(321), satisfying the requirements of that class, as required in 49 CFR Section 383.117.

b. To obtain a school bus endorsement, the applicant must qualify for a passenger vehicle endorsement and take the skills test in a school bus, as defined in rule 761—607.3(321), in the same vehicle class as the applicant will drive, as required in 49 CFR Section 383.123. Up to and including September 30, 2005, the skills test for a school bus endorsement is waived for an applicant meeting the requirements of 49 CFR Section 383.123(b).

c. To remove an air brake or full air brake restriction, the applicant must take the skills test in a vehicle equipped with an air brake system, as defined in rule 761—607.3(321) and as required in 49 CFR Section 383.113.

d. To remove a manual transmission restriction, the applicant must take the skills test in a vehicle equipped with a manual transmission, as defined in rule 761—607.3(321).

607.28(5) Skills test scoring. Passing scores for a skills test shall meet the standards contained in 49 CFR Section 383.135(b).

607.28(6) Military waiver. The department may waive the requirement that an applicant pass a required skills test for an applicant who is on active duty in the military service or who has separated from such service in the past year, provided the applicant meets the requirements of Iowa Code subsection 321.188(6).

607.28(7) Locations. The skills test for a commercial driver’s license shall be given only at specified locations where adequate testing facilities are available. An applicant may contact any driver’s license examination station for the location of the nearest skills testing station. A skills test by appointment shall be offered only at specified regional test sites.

This rule is intended to implement Iowa Code sections 321.186 and 321.188.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 3889C, IAB 3/14/18, effective 4/18/18]


761—607.30(321) Third-party testing.

607.30(1) Purpose and definitions. The skills test required by rule 761—607.28(321) may be administered by third-party testers and third-party skills test examiners approved and certified by the
department. For the purpose of administering third-party skills testing and this rule, the following definitions shall apply:

“Community college” means an Iowa community college established under Iowa Code chapter 260C.

“Iowa-based motor carrier” means a motor carrier or its subsidiary that has its principal place of business in the state of Iowa and operates a permanent commercial driver training facility in the state of Iowa.

“Motor carrier” means the same as defined in 49 CFR Section 390.5.

“Permanent commercial driver training facility” means a facility dedicated to a program of commercial driving instruction that is offered to employees or potential employees of the motor carrier as incident to the motor carrier’s commercial operations, that requires at least 40 hours of instruction, and that includes fixed and permanent structures and facilities for the off-road portions of commercial driving instruction, including classroom, pretrip inspection, and basic vehicle control skills. A permanent commercial driver training facility must include a fixed and paved or otherwise hard-surfaced area for basic vehicle control skills testing that is permanently marked and capable of inspection and measurement by the department.

“Skills test” means the skills test required by rule 761—607.28(321).

“Subsidiary” means a company that is partly or wholly owned by a motor carrier that holds a controlling interest in the subsidiary company.

“Third-party skills test examiner” means the same as defined in 49 CFR Section 383.5.

“Third-party tester” means the same as defined in 49 CFR Section 383.5.

607.30(2) Certification of third-party testers.

a. The department may certify as a third-party tester a community college or Iowa-based motor carrier to administer skills tests. A community college or Iowa-based motor carrier that seeks certification as a third-party tester shall contact the department’s office of driver services and schedule a review of the proposed testing program, which shall include the proposed testing courses and facilities, information sufficient to identify all proposed third-party skills test examiners, and any other information necessary to demonstrate compliance with 49 CFR Section 383.75.

b. No community college or Iowa-based motor carrier shall be certified to conduct third-party testing unless and until the community college or Iowa-based motor carrier enters an agreement with the department that meets the requirements of 49 CFR Section 383.75 and demonstrates sufficient ability to conduct skills tests in a manner that consistently meets the requirements of 49 CFR Section 383.75.

c. The department shall issue a certified third-party tester a certificate of authority that identifies the classes and types of vehicles for which skills tests may be administered. The certificate shall be valid for the duration of the agreement executed pursuant to paragraph 607.30(2) “b,” unless revoked by the department for engaging in fraudulent activities related to conducting skills tests or failing to comply with the requirements, qualifications, and standards of this chapter, the agreement, or 49 CFR Section 383.75.

607.30(3) Certification of third-party skills test examiners.

a. A certified third-party tester shall not employ or otherwise use as a third-party skills test examiner a person who has not been approved and certified by the department to administer skills tests. Each certified third-party tester shall submit for approval the names of all proposed third-party skills test examiners on a form provided by the department. The department shall not approve as a third-party skills test examiner a person who does not meet the requirements, qualifications and standards of 49 CFR Sections 383.75 and 384.228, including but not limited to all required training and examination and a nationwide criminal background check. The criteria for passing the nationwide criminal background check shall include no felony convictions within the last ten years and no convictions involving fraudulent activities.

b. The department shall issue a certificate of authority for each person certified as a third-party skills test examiner that identifies the certified third-party tester for which the person will administer skills tests and the classes and types of vehicles for which the person may administer skills tests. The certificate shall be valid for a period of four years from the date of issuance of the certificate.
c. The department shall revoke the certificate if the person holding the certificate does not administer skills tests to at least ten different applicants per calendar year; does not successfully complete the refresher training required by 49 CFR Section 384.228 every four years; is involved in fraudulent activities related to conducting skills tests; or otherwise fails to comply with and meet the requirements, qualifications and standards of this chapter or 49 CFR Sections 383.75 and 384.228.

d. A third-party skills test examiner who is also a skills instructor shall not administer a skills test to an applicant who received skills training from that third-party skills test examiner.

607.30(4) Bond. As a condition of certification, an Iowa-based motor carrier must maintain a bond in the amount of $50,000 to pay for the retesting of drivers in the event that the third-party tester or one or more of its third-party skills test examiners are involved in fraudulent activities related to conducting skills tests of applicants for a commercial driver’s license.

607.30(5) Limitation applicable to Iowa-based motor carriers. An Iowa-based motor carrier certified as a third-party tester may only administer the skills test to persons who are enrolled in the Iowa-based motor carrier’s commercial driving instruction program and shall not administer skills tests to persons who are not enrolled in that program.

607.30(6) Training and refresher training for third-party skills test examiners. All training and refresher training required under this rule shall be provided by the department, in form and content that meet the recommendations of the American Association of Motor Vehicle Administrators’ International Third-Party Examiner/Tester Certification Program.

This rule is intended to implement Iowa Code section 321.187.

[ARC 2530C, IAB 5/11/16, effective 6/15/16]

761—607.31(321) Test results.

607.31(1) Period of validity. Passing knowledge and skills test results shall remain valid for a period of one year.

607.31(2) Retesting. Subject to rule 761—607.28(321), an applicant shall be required to repeat only the knowledge test(s) or part(s) of the skills test that the applicant failed. An applicant who fails a test shall not be permitted to repeat that test the same day.

607.31(3) Skills test results from other states. As required by 49 CFR Section 383.79, the department shall accept the valid results of a skills test administered to an applicant who is domiciled in the state of Iowa and that was administered by another state, in accordance with 49 CFR Part 383, Subparts F, G and H, in fulfillment of the applicant’s testing requirements under 49 CFR Section 383.71 and the state’s test administration requirements under 49 CFR Section 383.73. The results must be transmitted directly from the testing state to the department as required by 49 CFR Section 383.79.

607.31(4) Skills test results from certified third-party testers. A third-party skills tester certified under rule 761—607.30(321) shall transmit the skills test results of tests administered by the third-party tester through secure electronic means determined by the department. The department may retest any person who has passed a skills test administered by a certified third-party tester if it appears to the department that the skills test administered by the third-party tester was administered fraudulently or improperly, and as needed to meet the third-party skills test examiner oversight requirements of 49 CFR Section 383.75(a)(5).

This rule is intended to implement Iowa Code sections 321.180, 321.186, 321.187 and 321.188.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 3689C, IAB 3/14/18, effective 4/18/18]

761—607.32 to 607.34 Reserved.

761—607.35(321) Issuance of commercial driver’s license and commercial learner’s permit. A commercial driver’s license or commercial learner’s permit issued by the department shall include the information and markings required by Iowa Code section 321.189(2)(b).

This rule is intended to implement Iowa Code section 321.189.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

761—607.37(321) Commercial driver’s license renewal. The department shall administer commercial driver’s license renewals as required by 49 CFR Section 383.73.

607.37(1) Licensee requirements. To renew a commercial driver’s license, the licensee shall apply at a driver’s license examination station and complete the following requirements:

a. The licensee shall make a written self-certification of type of driving as required by rule 761—607.50(321) and provide a current medical examiner’s certificate if required.

b. If the licensee has and wishes to retain a hazardous material endorsement, the licensee shall pass the test required in 49 CFR Section 383.121 and comply with the Transportation Security Administration security threat assessment standards specified in 49 CFR Sections 383.71(b)(8) and 383.141 for such endorsement. A lawful permanent resident of the United States must also provide the licensee’s U.S. Citizenship and Immigration Services alien registration number.

c. The licensee shall provide proof of citizenship or lawful permanent residency and state of domicile as required by rule 761—607.15(321) and 49 CFR 383.73(d)(7). Proof of citizenship or lawful permanent residency is not required if the licensee provided such proof at initial issuance or a previous renewal or upgrade of the license and the department has a notation on the licensee’s record confirming that the required proof of legal citizenship or legal presence check was made and the date on which it was made.

d. If the licensee is domiciled in a foreign jurisdiction and renewing a non-domiciled commercial driver’s license, the licensee must provide a document required by 49 CFR 383.71(f) at each renewal.

607.37(2) Early renewal. A valid commercial driver’s license may be renewed 90 days before the expiration date. If this is impractical, the department for good cause may renew a license earlier, not to exceed 364 days prior to the expiration date. The department may allow renewal earlier than 364 days prior to the expiration date for active military personnel being deployed due to actual or potential military conflict.

This rule is intended to implement Iowa Code sections 321.186, 321.188 and 321.196. [ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

761—607.38(321) Transfers from another state. Upon initial application for an Iowa license, an Iowa resident who has a valid commercial driver’s license from a former state of residence is not required to retest except as specified in Iowa Code subsection 321.188(5) but is required to pay the applicable endorsement and restriction removal fees.

This rule is intended to implement Iowa Code sections 321.188 and 321.191.

761—607.39(321) Disqualification.

607.39(1) Date. A disqualifying act, action or offense under Iowa Code section 321.208, that occurred before July 1, 1990, shall not be grounds for disqualification from operating a commercial motor vehicle.

607.39(2) Notice. A 30-day advance notice of disqualification shall be served by the department in accordance with rule 761—615.37(321). Pursuant to Iowa Code subsection 321.208(12), a peace officer on behalf of the department may serve the notice of disqualification immediately.

607.39(3) Hearing and appeal process. A person who has received a notice of disqualification may contest the disqualification in accordance with 761—615.38(17A,321).

607.39(4) Reduction of lifetime disqualification. Reserved.

This rule is intended to implement Iowa Code chapter 17A and section 321.208. [ARC 2530C, IAB 5/11/16, effective 6/15/16]

761—607.40(321) Sanctions. When a person’s motor vehicle license is denied, canceled, suspended, revoked or barred, the person is also disqualified from operating a commercial motor vehicle.

This rule is intended to implement Iowa Code section 321.208.
761—607.41 to 607.44 Reserved.

761—607.45(321) Reinstatement. To reinstate a commercial driver’s license after completion of a period of disqualification, a person shall appear at a driver’s license examination station. The person must also meet the vision standards for licensing, pass the applicable knowledge test(s) and the skills test, and pay the required reinstatement fee and the fees for a new license.

This rule is intended to implement Iowa Code sections 321.191 and 321.208.

761—607.46 to 607.48 Reserved.

761—607.49(321) Restricted commercial driver’s license.

607.49(1) Scope. This rule pertains to the issuance of restricted commercial driver’s licenses to suppliers or employees of suppliers of agricultural inputs. Issuance is permitted by 49 CFR 383.3(f). A restricted commercial driver’s license shall meet all requirements of a regular commercial driver’s license, as set out in Iowa Code chapter 321 and this chapter of rules, except as specified in this rule.

607.49(2) Agricultural inputs. The term “agricultural inputs” means suppliers or applicators of agricultural chemicals, fertilizer, seed or animal feeds.

607.49(3) Validity.
   a. A restricted commercial driver’s license allows the licensee to drive a commercial motor vehicle for agricultural input purposes. The license is valid to:
      (1) Operate Group B and Group C commercial motor vehicles including tank vehicles and vehicles equipped with air brakes, except passenger vehicles.
      (2) Transport the hazardous materials listed in paragraph 607.49(3)“b.”
      (3) Operate only during the current, validated seasonal period.
      (4) Operate between the employer’s place of business and the farm currently being served, not to exceed 150 miles.
   b. A restricted commercial driver’s license is not valid for transporting hazardous materials requiring placarding, except as follows:
      (1) Liquid fertilizers such as anhydrous ammonia may be transported in vehicles or implements of husbandry with total capacities of 3,000 gallons or less.
      (2) Solid fertilizers such as ammonium nitrate may be transported provided they are not mixed with any organic substance.
      (3) A hazardous material endorsement is not needed to transport the products listed in the preceding subparagraphs.
   c. When not driving for agricultural input purposes, the license is valid for operating a noncommercial motor vehicle that may be legally operated under the noncommercial license held by the licensee.

607.49(4) Requirements.
   a. The applicant must have two years of previous driving experience. This means that the applicant must have held a license that permits unaccompanied driving for at least two years. This does not include a motorized bicycle license, a minor’s school license or a minor’s restricted license.
   b. The applicant must have a good driving record for the most recent two-year period, as defined in subrule 607.49(5).
   c. An applicant who currently holds a commercial driver’s license or a commercial learner’s permit is not eligible for issuance of a restricted commercial driver’s license.

607.49(5) Good driving record. A “good driving record” means a driving record showing:
   a. No multiple licenses.
   b. No driver’s license suspensions, revocations, disqualifications, denials, bars, or cancellations of any kind.
   c. No convictions in any type of motor vehicle for:
      (1) Driving under the influence of alcohol or drugs.
      (2) Leaving the scene of an accident.
(3) Committing any felony involving a motor vehicle.
(4) Speeding 15 miles per hour or more over the posted speed limit.
(5) Reckless driving, drag racing, or eluding or attempting to elude a law enforcement officer.
(6) Improper or erratic lane changes.
(7) Following too closely.
(8) A moving violation that contributed to a motor vehicle accident.
(9) A violation deemed serious under rule 761—615.17(321).

607.49(6) Issuance.

a. The knowledge and skills tests described in rules 761—607.27(321) and 761—607.28(321) are waived.
b. A restricted commercial driver’s license shall be coded with restriction “W” on the face of the driver’s license, with the restriction explained in text on the back of the driver’s license. In addition, the license shall be issued with a restriction stating the license’s period of validity.
c. The expiration date for a restricted commercial driver’s license that is converted to this license from another Iowa license shall carry the same expiration date as the previous license.
d. A restricted commercial driver’s license may be renewed for the period of time specified in Iowa Code section 321.196. The licensee’s good driving record shall be confirmed at the time of renewal.
e. The fee for a restricted commercial driver’s license shall be as specified in Iowa Code section 321.191.
f. On or before December 31, 2016, there are two periods of validity for commercial motor vehicle operation: March 15 through June 30, and October 4 through December 14. Validity shall not exceed 180 days in any 12-month period. Any period of validity authorized previously by another state’s license shall be considered a part of the 180-day maximum period of validity.
g. On or after January 1, 2017, a licensee may have up to three individual periods of validity for a restricted commercial driver’s license, provided the cumulative period of validity for all individual periods does not exceed 180 days in any calendar year. An individual period of validity may be 60, 90, or 180 consecutive days, at the election of the licensee. A licensee may add 30 days to an individual period of validity by applying for an extension, subject to the 180-day cumulative maximum period of validity. A request for extension must be made no later than the date of expiration of the individual period of validity for which an extension is requested; a request for extension made after that date shall be treated as a request for a new individual period of validity. An extension shall be calculated from the date of expiration of the individual period of validity for which an extension is requested. Any period of validity authorized previously by another state’s license shall be considered a part of the 180-day cumulative maximum period of validity.
h. A restricted commercial driver’s license must be validated for commercial motor vehicle operation for each individual period of validity. This means that the applicant/licensee must have the person’s good driving record confirmed at each application for an individual period of validity. Upon confirmation, the department shall issue a replacement license with a restriction validating the license for that individual period of validity, provided the person is otherwise eligible for the license. The fee for a replacement license shall be as specified in Iowa Code section 321.195.
i. The same process must be repeated for each individual period of validity within a calendar year.

This rule is intended to implement Iowa Code section 321.176B.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

761—607.50(321) Self-certification of type of driving and submission of medical examiner’s certificate.

607.50(1) Applicants for commercial learner’s permit or new, transferred, renewed or upgraded CDL.

a. A person shall provide to the department a self-certification of type of driving if the person is applying for:

(1) A commercial learner’s permit,
(2) An initial commercial driver’s license,  
(3) A transfer of a commercial driver’s license from a prior state of domicile to the state of Iowa,  
(4) Renewal of a commercial driver’s license, or  
(5) A license upgrade for a commercial driver’s license or an endorsement authorizing the operation of a commercial motor vehicle not covered by the current commercial driver’s license.

b. The self-certification shall be on a form or in a format, which may be electronic, as provided by the department.

607.50(2) Submission of medical examiner’s certificate by persons certifying to non-excepted interstate driving. Every person who self-certifies to non-excepted interstate driving must give the department a copy of the person’s current medical examiner’s certificate. A person who fails to provide a required medical examiner’s certificate shall not be allowed to proceed with an initial issuance, transfer, renewal, or upgrade of a license until the person gives the department a medical examiner’s certificate that complies with the requirements of this subrule, or changes the person’s self-certification of type of driving to a type other than non-excepted interstate driving. For persons submitting a current medical examiner’s certificate, the department shall post a medical certification status of “certified” on the person’s CDLIS driver’s record. A person who self-certifies to a type of driving other than non-excepted interstate shall have no medical certification status on the CDLIS driver’s record.

607.50(3) Maintaining certified status. To maintain a medical certification status of “certified,” a person who self-certifies to non-excepted interstate driving must give the department a copy of each subsequently issued medical examiner’s certificate valid for the person. The copy must be given to the department at least ten days before the previous medical examiner’s certificate expires.

607.50(4) CDL downgrade. If the medical examiner’s certificate or medical variance for a person self-certifying to non-excepted interstate driving expires or if the Federal Motor Carrier Safety Administration notifies the department that the person’s medical variance was removed or rescinded, the department shall post a medical certification status of “not certified” to the person’s CDLIS driver’s record and shall initiate a downgrade of the person’s commercial driver’s license or commercial learner’s permit. The medical examiner’s certificate of a person who fails to maintain a medical certification status of “certified” as required by subrule 607.50(3) shall be deemed to be expired on the date of expiration of the last medical examiner’s certificate filed for the person as shown by the person’s CDLIS driver’s record. The downgrade will be initiated and completed as follows:

a. The department shall give the person written notice that the person’s medical certification status is “not certified” and that the commercial motor vehicle privileges will be removed from the person’s commercial driver’s license or commercial learner’s permit 60 days after the date the medical examiner’s certificate or medical variance expired or the medical variance was removed or rescinded unless the person submits to the department a current medical certificate or medical variance or self-certifies to a type of driving other than non-excepted interstate.

b. If the person submits a current medical examiner’s certificate or medical variance before the end of the 60-day period, the department shall post a medical certification status of “certified” on the person’s CDLIS driver’s record and shall terminate the downgrade of the person’s commercial driver’s license or commercial learner’s permit.

c. If the person self-certifies to a type of driving other than non-excepted interstate before the end of the 60-day period, the department shall not remove the commercial motor vehicle privileges from the person’s commercial driver’s license or commercial learner’s permit, and the person will have no medical certification status on the person’s CDLIS driver’s record.

d. If the person fails to take the action in either paragraph 607.50(4)“b” or “c” before the end of the 60-day period, the department shall remove the commercial motor vehicle privileges from the person’s commercial driver’s license or commercial learner’s permit and shall leave the person’s medical certification status as “not certified” on the person’s CDLIS driver’s record.

607.50(5) Establishment or reestablishment of “certified” status. A person who has no medical certification status or whose medical certification status has been posted as “not certified” on the person’s CDLIS driver’s record may establish or reestablish the status as “certified” by submitting a current medical examiner’s certificate or medical variance to the department. A person who has failed
to self-certify to a type of driving or has self-certified to a type of driving other than non-excepted interstate must also make a self-certification of type of driving to non-excepted interstate driving. The department shall then post a medical certification status of “certified” on the person’s CDLIS driver’s record.

607.50(6) Reestablishment of the CDL privilege. A person whose commercial motor vehicle privileges have been removed from the person’s commercial driver’s license or commercial learner’s permit under the provisions of paragraph 607.50(4) “d” may reestablish the commercial motor vehicle privileges by either of the following methods:

a. Submitting a current medical examiner’s certificate or medical variance to the department. A person who has failed to self-certify to a type of driving must also make an initial self-certification of type of driving to non-excepted interstate driving. The department shall then post a medical certification status of “certified” on the person’s CDLIS driver’s record and reestablish the commercial motor vehicle privileges, provided that the person otherwise remains eligible for a commercial driver’s license or commercial learner’s permit.

b. Self-certifying to a type of driving other than non-excepted interstate. The department shall then reestablish the commercial motor vehicle privileges, provided that the person otherwise remains eligible for a commercial driver’s license or commercial learner’s permit; the person will have no medical certification status on the driver’s CDLIS driver’s record.

607.50(7) Change of type of driving. A person may change the person’s self-certification of type of driving at any time. As required by subrule 607.50(2), a person certifying to non-excepted interstate driving must give the department a copy of the person’s current medical examiner’s certificate prepared by a medical examiner.

607.50(8) Record keeping. The department shall comply with the medical record-keeping requirements set forth in 49 CFR Section 383.73.

This rule is intended to implement Iowa Code sections 321.182, 321.188 and 321.207.

[ARC 9954B, IAB 1/11/12, effective 1/30/12; ARC 0031C, IAB 3/7/12, effective 4/11/12; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

761—607.51(321) Determination of gross vehicle weight rating.

607.51(1) Actual weight prohibited. In determining whether the vehicle is a representative vehicle for the skills test and the group of commercial driver’s license for which the applicant is applying, the vehicle’s gross weight rating or gross combination weight rating must be used, not the vehicle’s actual gross weight or gross combination weight. For purposes of this rule, “gross weight rating” and “gross combination weight rating” mean as defined in 49 CFR Section 383.5.

607.51(2) Vehicle without legible manufacturer’s certificate label. To complete a skills test using a vehicle that has no legible manufacturer’s certification label, whether a power unit or towed vehicle, the applicant must provide documentation of the vehicle’s gross weight rating, such as a manufacturer’s certificate of origin, a title, or the vehicle identification number information for the vehicle. In the absence of such documentation, the vehicle may not be used, either alone or in combination.

This rule is intended to implement Iowa Code section 321.1.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]
[Filed 12/12/07, Notice 11/7/07—published 1/2/08, effective 2/6/08]
[Filed ARC 7902B (Notice ARC 7721B, IAB 4/22/09), IAB 7/1/09, effective 8/5/09]
[Filed Emergency ARC 9954B, IAB 1/11/12, effective 1/30/12]
[Filed ARC 0031C (Notice ARC 9955B, IAB 1/11/12), IAB 3/7/12, effective 4/11/12]
[Filed ARC 1714C (Notice ARC 1601C, IAB 9/3/14), IAB 11/12/14, effective 12/17/14]
[Filed Emergency ARC 2071C, IAB 8/5/15, effective 7/14/15]
[Filed ARC 2337C (Notice ARC 2070C, IAB 8/5/15), IAB 1/6/16, effective 2/10/16]
[Filed ARC 2530C (Notice ARC 2451C, IAB 3/16/16), IAB 5/11/16, effective 6/15/16]
[Filed ARC 2986C (Notice ARC 2878C, IAB 1/4/17), IAB 3/15/17, effective 4/19/17]
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[Filed ARC 3840C (Notice ARC 3700C, IAB 3/28/18), IAB 6/6/18, effective 7/11/18]
[Filed ARC 4401C (Notice ARC 4256C, IAB 1/30/19), IAB 4/10/19, effective 5/15/19]
[Filed ARC 4586C (Notice ARC 4476C, IAB 6/5/19), IAB 7/31/19, effective 9/4/19]
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Created by 1992 Iowa Acts, chapter 1140, section 8
[Prior to 8/21/91, see Veterans Affairs Department[841]]
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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 interdisciplinary 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.

"Interdisciplinary resident care committee" or "IRCC" 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 a member’s assessment data and developing a collaborative care plan for the individual member.

"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), as provided in Iowa Code chapters 144A, 144B, and 633. For applicant or member financial decisions, “legal representative” means conservator, power of attorney, fiduciary or representative payee.

"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.

"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.

"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]

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 Veterans Homes, Veterans Health Administration, M-1, Part 1, Chapter 3.11(h) (1), (2), and (3), and have prior DVA approval if the individual’s income level exceeds the established cap.

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:

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.

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: www.iowaveteranshome.org.
10.3(3) The applicant shall be scheduled for a physical examination by a medical provider, and the results of the examination shall be entered on the application by the examining medical provider. If the applicant has had a complete physical examination within three months of application, a copy of this physical shall suffice. 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. An affidavit signed by two members of the county commission of veterans affairs and notarized by the appropriate county official attesting to the best of their knowledge and belief that the applicant is a resident of that county and is an eligible applicant.

b. A copy of the veteran’s honorable discharge from the armed forces of the United States.

c. 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.

d. 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.

e. A copy of the applicant’s birth certificate.

f. A copy of divorce decrees or death certificate for the spouse, if applicable.

g. A completed “Personal Functional Assessment,” Form 475-0837.

h. A completed “Supplement to Application for Admission to the Iowa Veterans Home,” Form 475-0843.


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]

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 8014, 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 office and resident finance office for an admission interview.

10.6(3) During the interview in the admissions office with the admissions coordinator, 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.

10.6(4) During the interview with the resident finance office, the accounting technician will review the following items with the applicant or legal representative:

a. The applicant’s resources.

b. The member support, billing process and banking services.

10.6(5) 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(6) 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(7) 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]

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.
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.
The first ten days of each hospitalization. On the eleventh day the member’s bed shall be held without charge until the termination of hospital stay and member returns to IVH. 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]

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).

b. **Household goods, personal effects and one motor vehicle.**

   (2) 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, 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. 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.

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 $24,000 (the amount set by 441 IAC 75.5(3)“d” and “f,” Public Law 100-365 and Public Law 100-485), then that amount shall be protected for the spouse living in the community. If applicable, the next $24,000 shall be awarded to the member. Any resources over $48,000 shall be split one-half to the member and one-half to the spouse up to a predetermined amount set by the department of human services. All resources over the predetermined amount shall be awarded to the member unless it is determined that the member would never be eligible for Medicaid benefits; in this circumstance, assets will be split one-half to the member and one-half to the spouse. Other resources attributed to the spouse living in the community shall be determined by the department of human services through the attribution process.

(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(3D).

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(3D), 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]

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 shall be charged member support as if 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 shall be charged member support as if divestment did not occur.

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 9609B, 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, IVH will first take payment for the final support bill, which may include debts owed to the IVH arts and crafts and ceramics
program. If funds remain, IVH, upon receipt of documentation of the outstanding balance, will convey promptly the member’s funds to the funeral home or to the individual paying last funeral expenses. IVH will notify promptly the estate recovery program of the death of any IVH resident who has been on Title XIX. 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 administrator of 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 before the first 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]

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. Beginning on the eleventh day through the remainder of the hospitalization, 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. 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 past midnight of the day of return before another pass is 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]

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 Medicare office, whichever is appropriate.

[ARC 2675C, IAB 8/17/16, effective 9/21/16]

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.
  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 IRCC, 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]

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 IRCC, 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 IRCC 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 IRCC 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 IRCC 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]

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]

GROUND 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.

[Filed 2/19/76, Notice 1/12/76—published 3/8/76, effective 4/12/76]
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.
WORKERS’ COMPENSATION DIVISION[876]

[Prior to 9/24/86, see Industrial Commissioner[500]. Renamed Division of Industrial Services under the “umbrella” of Employment Services Department by 1986 Iowa Acts, Senate File 2175]

[Prior to 1/29/97 see Industrial Services Division[343]. Reorganized under “umbrella” of the Department of Workforce Development[871] by 1996 Iowa Acts, chapter 1186]

[Prior to 7/29/98 see Industrial Services Division[873]]

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876—2.1(86) Extending time and continuances. For good cause the workers’ compensation commissioner or the commissioner’s designee may modify the time to comply with any rule.

876—2.2(85A,85B,86,87) Applicability. When appropriate, all rules shall apply to Iowa Code chapters 85A, 85B, 86 and 87 as well as chapter 85.

876—2.3(86,87) Representative within the state. All licensed insurers, foreign and domestic, insuring workers’ compensation and all employers relieved from insurance pursuant to Iowa Code section 87.11 shall designate one or more persons geographically located within the borders of this state, which person or persons shall be knowledgeable of the Iowa workers’ compensation law and rules and shall be given the authority and have the responsibility to expedite the handling of all matters within the scope of Iowa Code chapters 85, 85A, 85B, 86, and 87.

The Iowa workers’ compensation commissioner shall be advised by letter of the name, address, and telephone number of each of the persons so designated. Any change in the identity, address or telephone number of the persons so designated shall be reported to the Iowa workers’ compensation commissioner within ten days after such change occurs.

876—2.4(85,86) Guides to evaluation of permanent impairment. The Guides to the Evaluation of Permanent Impairment, Fifth Edition, published by the American Medical Association are adopted for determining the extent of loss or percentage of impairment for permanent partial disabilities and payment of weekly compensation for permanent partial scheduled injuries under Iowa Code section 85.34(2) not involving a determination of reduction in an employee’s earning capacity. Payment so made shall be recognized by the workers’ compensation commissioner as a prima facie showing of compliance by the employer or insurance carrier with the foregoing sections of the Iowa workers’ compensation Act. Nothing in this rule shall be construed to prevent the presentations of other medical opinions or other material evidence for the purpose of establishing that the degree of permanent disability to which the claimant would be entitled would be more or less than the entitlement indicated in the Guides to the Evaluation of Permanent Impairment, Fifth Edition, when the reduction in earning capacity for all other permanent partial and permanent total disabilities is determined.

This rule is intended to implement Iowa Code sections 85.34(2) and 86.8.
[ARC 3528C, IAB 12/20/17, effective 1/24/18]

876—2.5(85,85A,85B,86) Use of workers’ compensation electronic system (WCES) for submission of filings. The division of workers’ compensation requires the filing of electronic data interchange (EDI) information, forms, petitions, pleadings, responses, and any other submissions to be effectuated by use of the workers’ compensation electronic system (WCES). The website address for WCES is efile.iowaworkcomp.gov. The division of workers’ compensation may provide exceptions to the mandatory use of WCES in contested claims. Any electronic filing that is quarantined due to a virus will not be considered received.

2.5(1) The division of workers’ compensation shall grant exceptions for filing in WCES for good cause, such as a power outage at the filer’s office or home.

2.5(2) The division of workers’ compensation shall grant exceptions for part or the duration of a case for good cause, such as when a filer cannot use a computer or does not have regular access to the Internet at home through a device capable of displaying documents. This inability to file in or follow the case could put a filer at a disadvantage before the agency. Only a deputy workers’ compensation commissioner or the workers’ compensation commissioner can grant an exception for the duration of a case.
**2.5(3)** The commissioner or the commissioner’s designee shall allow the filing of paper documents in case of a systemic failure of WCES.

This rule is intended to implement Iowa Code chapters 85, 85A, 85B and 86.
[ARC 4568C, IAB 7/31/19, effective 7/10/19]

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**876—2.6(85,85A,85B,86) Information to employees.** An employer or its insurance carrier filing a final subsequent report of injury (SROI) with the workers’ compensation commissioner (see 876—subrule 3.1(2)) shall also mail a copy of the information contained on the final subsequent report of injury to the employee at the employee’s last-known address.

This rule is intended to implement Iowa Code sections 85.26, 86.8, 86.11 and 86.13.

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**876—2.7(86) Official record.** The electronic record made and maintained by the division of workers’ compensation is the official record of a case unless different means are ordered by the commissioner or deputy commissioner or unless a proceeding is not required to use WCES. The division may require parties to scan and file in WCES pleadings, exhibits and other records that were filed as paper documents before the establishment of WCES.

This rule is intended to implement Iowa Code chapters 85, 85A, 85B and 86.
[ARC 4568C, IAB 7/31/19, effective 7/10/19]

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**876—2.8(86) Document requirements.** Pleadings, responses to pleadings, exhibits, and transcripts submitted to the division of workers’ compensation shall be scanned, attached, and filed in portable document format (pdf) or as image-on-text documents (searchable pdf). A hearing report or proposed order or proposed ruling shall be submitted in Microsoft Word format. Transcripts submitted shall include an index. Filings shall not exceed 30 megabytes (MB). Documents exceeding 30 MB shall be divided and submitted as separate attachments to comply with this size limit. All filings pursuant to this rule shall be submitted via WCES unless otherwise ordered by the workers’ compensation commissioner, a deputy workers’ compensation commissioner or other agency staff who have been delegated authority by the commissioner. Audio or video files shall use MP3 or MP4 format and should be submitted with a virus-scanned USB drive or DVD and shall not exceed 500 MB for each filing.

This rule is intended to implement Iowa Code chapters 85, 85A, 85B and 86.
[ARC 4568C, IAB 7/31/19, effective 7/10/19]

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**876—2.9(86) Effective date of WCES rules.** All rules and forms of the division of workers’ compensation that relate to WCES shall be effective July 16, 2019, for EDI filing and July 22, 2018, for filing in claims before the agency, or when WCES is available to the public, whichever is later.

This rule is intended to implement Iowa Code chapters 17A, 85, 85A, 85B and 86.
[ARC 4568C, IAB 7/31/19, effective 7/10/19]

[Emergency filed and effective 9/19/75—published 10/6/75]
[Filed 11/17/75, Notice 10/6/75—published 12/1/75, effective 1/5/76]
[Filed 8/16/76, Notice 7/12/76—published 8/23/76, effective 9/27/76]
[Filed 8/3/77, Notice 6/29/77—published 8/24/77, effective 9/28/77]
[Filed emergency 6/18/82—published 7/7/82, effective 7/1/82]
[Editorially transferred from [500] to [343], IAC Supp. 9/24/86, see IAB 7/16/86]
[Filed 8/26/94, Notice 7/20/94—published 9/14/94, effective 10/19/94]
[Filed 1/13/95, Notice 12/7/94—published 2/1/95, effective 3/8/95]
[Filed 1/10/97, Notice 12/4/96—published 1/29/97, effective 3/5/97]
[Filed emergency 7/1/98—published 7/29/98, effective 7/1/98]
[Filed 5/12/00, Notice 4/5/00—published 5/31/00, effective 7/5/00]
[Filed 2/15/02, Notice 1/9/02—published 3/6/02, effective 4/10/02]
[Filed emergency 4/2/08—published 4/23/08, effective 4/2/08]
[Filed ARC 3528C (Notice ARC 3414C, IAB 10/25/17), IAB 12/20/17, effective 1/24/18]
[Filed Emergency After Notice ARC 4568C (Notice ARC 4472C, IAB 6/5/19), IAB 7/31/19, effective 7/10/19]
CHAPTER 3
FORMS

876—3.1(17A) Forms. The following forms are available from the division of workers’ compensation for use in matters under the jurisdiction of the workers’ compensation commissioner. Insurance carriers, self-insured employers, or their adjusting agents may reproduce the forms in which event the name, address, telephone number, and identification number may be imprinted. The current revision of the form must be used. Each form is identified by a form number. This form number follows each form name listed below and is used when requesting that specific form.

3.1(1) First report of injury. The first report of injury (FROI) contains general information concerning the employee, the employer and the claimed injury. It is to be filed whether or not an adjudication or admission of liability for the injury exists and is to be filed as provided in Iowa Code section 86.11 and 876—Chapter 11. The first report of injury is to be filed when demanded by the commissioner pursuant to Iowa Code section 86.12 and when an employer is served with an original notice and petition that alleges an injury for which a first report has not been filed. If an original notice and petition alleges multiple injury dates, only one first report of injury should be filed, and the date of injury reported should be the date the reporter uses when adjusting the claim.

3.1(2) Subsequent report of injury (SROI).

a. The subsequent report of injury (SROI) provides for filing of notice of commencement of payments, correcting erroneous claim information, supplying additional information, denying compensability, agreeing to the weekly benefit rate and agreeing to make payments under the Workers’ Compensation Act, reporting the status of a claim, or recording benefits paid. Notice of commencement of payments shall be filed within 30 days of the first payment. When liability on a claim is denied, a letter shall be sent to claimant stating reasons for denial. The SROI shall also be filed when compensation is terminated or interrupted. Medical data supporting the action taken shall be filed when temporary total disability or temporary partial disability exceeds 13 weeks or when the employee sustains a permanent disability.

b. The employer and insurance carrier who are required to file medical data shall file the medical data in WCES. The employer or insurance carrier or the employer’s or insurance carrier’s agent shall register in WCES to file the medical data. The filer will receive a status update for the information the filer submits based upon the status the filer selects and for which the filer is approved in WCES.

3.1(3) Form No. 2A—claim activity report. (Form No. 14-0003) Rescinded IAB 3/6/02, effective 4/10/02.

3.1(4) Form No. 2B—supplemental information report. (Form No. 14-9999) Rescinded IAB 3/6/02, effective 4/10/02.

3.1(5) Form No. 12—waiver on account of physical defect. (Form No. 14-0029) Rescinded IAB 10/25/06, effective 11/29/06.

3.1(6) Form—rehabilitation referral and acknowledgment. (Form No. 309-5051) Rescinded IAB 7/31/19, effective 7/10/19.

3.1(7) Form—original notice and petition. The following forms are types of original notice and petition: original notice and petition—Form 100 (Form No. 14-0005); original notice, petition, answer and order concerning independent medical examination—Form 100A (Form No. 14-0007); answer and order concerning independent medical examination—Form 100A (Form No. 14-0007A); original notice, petition, answer and order concerning vocational rehabilitation program benefit—Form 100B (Form No. 14-0009); answer concerning vocational rehabilitation program benefit—Form 100B (Form No. 14-0009A); original notice, petition, and answer concerning application for alternate medical care—Form 100C (Form No. 14-0011); answer concerning application for alternate medical care—Form 100C (Form No. 14-0011A); original notice, petition, and answer concerning application for vocational training and education—Form 100D (Form No. 14-0012); answer concerning application for vocational training and education—Form 100D (Form No. 14-0012A); original notice and petition...
for full commutation of all remaining benefits of ten weeks or more 876 IAC 6.2(6)—Form 9 (Form No. 14-0013); checklist for full commutation (Form No. 14-0015); original notice and petition and order for partial commutation—Form 9A (Form No. 14-0017); and checklist for partial commutation (Form No. 14-0019). See rule 876—4.6(85.86,17A) for further descriptions.

3.1(8) Form—subpoena. (Form No. 14-0035) This form is the witness subpoena, which is used to require a witness to appear and testify, and the Subpoena Duces Tecum, which is used to require a witness to appear and to bring specified books and records.

3.1(9) Form—corporate officer exclusion. (Form No. 14-0061) This form is the corporate officer exclusion which is used for corporate officers to reject workers’ compensation or employers’ liability.

3.1(10) Form—attorney lien. (Form No. 14-0039) Rescinded IAB 3/6/02, effective 4/10/02.

3.1(11) Form—application and consent order for payment of benefits. (Form No. 14-0037) This form is the application and consent order for payment of benefits under Iowa Code section 85.21 which is used by an employer or an insurance carrier to pay weekly and medical benefits without admitting liability and to be able to seek reimbursement from another carrier or employer.


3.1(13) Form—dispute resolution conference report. (Form No. 14-0041) This form is the dispute resolution conference report which is used to provide information for a dispute resolution pursuant to rule 876—4.40(73GA,ch1261).

3.1(14) Form—forms order blank. (Form No. 14-0031) Rescinded IAB 7/31/19, effective 7/10/19.

3.1(15) Form—agreement for settlement. (Form No. 14-0021) Rescinded IAB 10/25/06, effective 11/29/06.

3.1(16) Form—contested case settlement. (Form No. 14-0025) Rescinded IAB 10/25/06, effective 11/29/06.

3.1(17) Form—authorization for release of information regarding claimants seeking workers’ compensation benefits. (Form No. 14-0043) This form is used for the release of information concerning an employee’s physical or mental condition relative to a workers’ compensation claim.

3.1(18) Form No. 9—original notice and petition and order for commutation of all remaining benefits of ten weeks or more 876 IAC 6.2(6). (Form No. 14-0013) This form contains data relevant to benefits paid and those to be paid by commutation when all unaccrued benefits are due. Signatures of the parties are necessary. Approval by the workers’ compensation commissioner or a deputy commissioner is necessary. The form contains language of release.

3.1(19) Form No. 9A—original notice and petition and order for partial commutation. (Form No. 14-0017) This form contains the same data and requirements as Form No. 9. However, all remaining benefits are not commuted. No language of release is contained.

3.1(20) Form—prehearing conference report. (Form No. 14-0049) Rescinded IAB 10/25/06, effective 11/29/06.

3.1(21) Form—agreement for settlement. (Form No. 14-0021) This form is used to file an agreement for settlement pursuant to Iowa Code section 85.35(2).

3.1(22) Form—compromise settlement. (Form No. 14-0025) This form is used to file a compromise settlement pursuant to Iowa Code section 85.35(3).

3.1(23) Form—combination settlement. (Form No. 14-0159) This form is used to file a combination settlement pursuant to Iowa Code section 85.35(4).

3.1(24) Form—contingent settlement. (Form No. 14-0161) This form is used to file a contingent settlement pursuant to Iowa Code section 85.35(5).

3.1(25) Form—claimant’s statement. (Form No. 14-0163) This form is used for any type of settlement when the claimant is not represented by an attorney.

3.1(26) Form—application to defer payment of filing fees, financial affidavit and order. (Form No. 14-0075) This form is used to request a deferral of payment of filing fees. This form is not initially filed through WCES.

3.1(27) Form—claimant’s confidential information sheet. (Form No. 14-0171) This form is used to provide details about the claimant’s identifying information so that claims may be matched in WCES. This form is required to be filed by a claimant when the claimant is excused from using WCES.
3.1(28) Form—nonelection of workers’ compensation or employers’ liability coverage. (Form No. 14-0175) This form is used for exclusion from liability coverage pursuant to Iowa Code section 87.22.

3.1(29) Form—application to be excused from filing in WCES. (Form No. 14-0176) This form is used by a self-represented party to request permission to file and serve documents in paper form and be excused from using WCES.

These rules are intended to implement Iowa Code section 17A.3(1) “b.”

[Editorially transferred from [500] to [343], IAC Supp. 9/24/86, see IAB 7/16/86]
[Filed 8/26/94, Notice 7/20/94—published 9/14/94, effective 10/19/94]
[Filed 1/10/97, Notice 12/4/96—published 1/29/97, effective 3/5/97]
[Filed emergency 7/1/98—published 7/29/98, effective 7/1/98]
[Filed 2/15/02, Notice 1/9/02—published 3/6/02, effective 4/10/02] 0
[Filed 4/12/02, Notice 3/6/02—published 5/1/02, effective 7/1/02]
[Filed 11/4/05, Notice 9/14/05—published 11/23/05, effective 1/1/06]
[Filed 10/5/06, Notice 8/30/06—published 10/25/06, effective 11/29/06]
[Filed ARC 3528C (Notice ARC 3414C, IAB 10/25/17), IAB 12/20/17, effective 1/24/18]
[Filed Emergency After Notice ARC 4568C (Notice ARC 4472C, IAB 6/5/19), IAB 7/31/19, effective 7/10/19]

◊ Two or more ARCs

0 See IAB Industrial Services, Division of [343]
CHAPTER 4
CONTESTED CASES
[Prior to 9/24/86 see Industrial Commissioner[500]]
[Prior to 1/29/97 see Industrial Services Division[343]]
[Prior to 7/29/98 see Industrial Services Division[873][Ch 4]

876—4.1(85,85A,85B,86,87,17A) Contested cases. Contested case proceedings before the workers’ compensation commissioner are:

4.1(1) Arbitration (Iowa Code section 86.14).
4.1(2) Review of award or settlement (review-reopening, Iowa Code section 86.14).
4.1(3) Benefits under Iowa Code section 85.27.
4.1(4) Death and burial benefits (Iowa Code sections 85.28, 85.29, 85.31).
4.1(5) Determination of dependency (Iowa Code sections 85.42, 85.43, 85.44).
4.1(6) Equitable apportionment (Iowa Code section 85.43).
4.1(7) Second injury fund (Iowa Code section 85.63 et seq.).
4.1(8) Vocational rehabilitation benefits (Iowa Code section 85.70(1)).
4.1(9) Vocational training and education (Iowa Code section 85.70(2)).
4.1(10) Approval of fees under Iowa Code section 86.39.
4.1(11) Commutation (Iowa Code section 85.45 et seq.).
4.1(12) Employee’s examination (Iowa Code section 85.39).
4.1(13) Employer’s examination or sanctions (Iowa Code section 85.39).
4.1(15) Applications for alternate medical care (Iowa Code section 85.27).
4.1(16) Determination of liability, reimbursement for benefits paid and recovery of interest (Iowa Code section 85.21).
4.1(17) Interest (Iowa Code section 85.30).
4.1(18) Penalty (Iowa Code section 86.13).
4.1(19) Application for approval of third-party settlement (Iowa Code section 85.22).
4.1(20) Matters that would be a contested case if there were a dispute over the existence of material facts.
4.1(21) Any other issue determinable upon evidential hearing which is under the jurisdiction of the workers’ compensation commissioner.

This rule is intended to implement Iowa Code sections 17A.2(2) and 86.8 and the statutory sections noted in each category of the rule.

[ARC 3528C, IAB 12/20/17, effective 1/24/18]

876—4.2(86) Separate evidentiary hearing or consolidation of proceedings. A person presiding over a contested case proceeding in a workers’ compensation matter may conduct a separate evidentiary hearing for determination of any issue in the contested case proceeding which goes to the whole or any material part of the case. An order determining the issue presented shall be issued before a hearing is held on the remaining issues. The issue determined in the separate evidentiary hearing shall be precluded at the hearing of the remaining issues. If the order on the separate issue does not dispose of the whole case, it shall be deemed interlocutory for purposes of appeal.

When any contested case proceeding shall be filed prior to or subsequent to the filing of an arbitration or review-reopening proceeding and is of such a nature that it is an integral part of the arbitration or review-reopening proceeding, it shall be deemed merged with the arbitration or review-reopening proceeding. No appeal to the commissioner of a deputy commissioner’s order in such a merged proceeding shall be had separately from the decision in arbitration or review-reopening unless appeal to the commissioner from the arbitration or review-reopening decision would not provide an adequate remedy.

Entitlement to denial or delay benefits provided in Iowa Code section 86.13 shall be pled, and if pled, discovery shall be limited to matters discoverable in the absence of such pleading unless it is bifurcated. The claimant may bifurcate the denial or delay issue by filing and serving a notice of bifurcation at any
time before a case is assigned for hearing, in which case discovery on that issue may proceed only after the final decision of the agency on all other issues.

This rule is intended to implement Iowa Code sections 86.13, 86.18 and 86.24.

876—4.3(85,85A,86,87) Compliance proceedings. If the workers’ compensation commissioner shall have reason to believe that there has not been compliance with the workers’ compensation law by any person or entity, the commissioner may on the commissioner’s own motion give notice to the person or entity and schedule a hearing for the purpose of determining whether or not there has been compliance by the person or entity. The notice shall state the time and place of the hearing and a brief statement of the matters to be considered. The notice of hearing may be given by ordinary mail or by WCES if the alleged noncompliant person or entity is registered in WCES and is currently participating in a contested case using WCES and may be given to the insurer for the employer in lieu of the employer as permitted by Iowa Code section 87.10 if the insurer has filed a report, pleading or motion that acknowledges that it is the insurer for the claim at issue. Following the hearing, the commissioner may issue a finding regarding compliance. In the event a failure to comply is found, the commissioner may impose sanctions in accordance with Iowa Code section 86.12, 86.13 or 86.13A or order compliance within a specified time and under specified circumstances. The workers’ compensation commissioner may file a certified copy of the order in an appropriate district court and may file a certified copy of the order with the Iowa insurance division of the department of commerce with a request for action by the insurance division upon failure to comply with the order.

Nothing in this rule shall prevent the workers’ compensation commissioner from conducting an informal conference with any person or entity concerning problems of compliance prior to the initiation of a compliance proceeding.

[ARC 4568C, IAB 7/31/19, effective 7/10/19]

876—4.4(86) Request for hearing. Unless otherwise ordered, a hearing shall not be held in proceedings under 4.1(8) to 4.1(13), unless requested in writing by the petitioner in the original notice or petition or by the respondent within ten days following the time allowed by these rules for appearance.

[ARC 3528C, IAB 12/20/17, effective 1/24/18]

876—4.5(86) Commencement by commissioner. In addition to an aggrieved party, the commissioner may initiate proceedings under 4.1(10). The proceeding may be held before a deputy commissioner or the commissioner. The workers’ compensation commissioner shall be the only person to commence a proceeding under 4.1(14), unless such authority is specifically delegated by the workers’ compensation commissioner to a deputy commissioner concerning a specific matter.

[ARC 3528C, IAB 12/20/17, effective 1/24/18]

876—4.6(85,86,17A) Original notice and petition. A petition or application must be delivered or filed with the original notice unless original notice Form 100, Form 100A, Form 100B, or Form 100D of the division of workers’ compensation is used.

The original notice Form 100, Form 100A, Form 100B, Form 100C, Form 100D, or a determination of liability reimbursement for benefits paid and recovery of interest form shall provide for the data required in Iowa Code section 17A.12(2) and shall contain factors relevant to the contested case proceedings listed in 876—4.1(85,85A,85B,86,87,17A). Form 100 is to be used for all contested case proceedings except as indicated in this rule. Form 100A is to be used for the contested case proceedings provided for in subrules 4.1(12) and 4.1(13). Form 100B is to be used for the contested case proceeding provided for in subrule 4.1(8). Form 100C is to be used for the contested case proceeding provided for in subrule 4.1(15) and rule 876—4.48(17A,85,86). Form 100D is to be used for the contested case proceeding provided for in rule 876—4.50(85). The application and consent order for payment of benefits under Iowa Code section 85.21 is to be used for contested case proceedings brought under Iowa Code section 85.21. When a commutation is sought, Form No. 9 or Form No. 9A must be filed in addition to any other document. The petition for declaratory order, approval of attorney fees,
determination of compliance and other proceedings not covered in the original notice forms must accompany the original notice.

At the same time and in the same manner as service of the original notice and petition, the claimant shall serve a patient’s waiver using Form 14-0043 (authorization for release of information regarding claimants seeking workers’ compensation benefits), or a substantially equivalent form, which shall not be revoked until conclusion of the contested case. The claimant shall provide the patient’s waivers in other forms and update the patient’s waivers as necessary to permit full disclosure of discoverable information whenever requested by a medical practitioner or institution.

A separate original notice and petition shall be filed for each claim that seeks benefits due to the occurrence of an injury, occupational disease or occupational hearing loss. The original notice and petition shall allege a specific date of occurrence consisting of a day, month and year. Alternate or multiple dates of occurrence may be alleged in the same original notice and petition if the claim or claims arose from the same occurrence or series of occurrences and uncertainty exists concerning the correct date of occurrence or the number of occurrences. An employee may join any number of employers or insurance carriers in the same original notice and petition if the claim is made against them jointly, severally or in the alternative. The remedy for misjoinder must be requested by motion within a reasonable time after the grounds become known, but in no event later than the claimant’s case preparation completion date. All remedies will be applied without prejudice to any claim or defense. In addition to the remedies contained in Iowa Rule of Civil Procedure 1.236, the workers’ compensation commissioner may order that parts of a claim be severed and proceeded with separately or that separate related claims be joined or consolidated for administrative convenience or for any good cause. If a correction is ordered but not made by a date specified in the order, the original notice and petition may be dismissed without further notice. If the correction is made within the specified time, the correction relates back to the date of the initial filing for purposes of the statute of limitations.

This rule is intended to implement Iowa Code sections 85.27, 85.45, 85.48, and 17A.12.

[ARC 3528C, IAB 12/20/17, effective 1/24/18]

876—4.7(86,17A) Delivery of notice, orders, rulings and decisions. Delivery of the original notice shall be made by the petitioning party as provided in Iowa Code section 17A.12(1) except that a party may deliver the original notice on a nonresident employer as provided in Iowa Code section 85.3. A proposed or final decision, order or ruling may be delivered by the division of workers’ compensation to any party by regular mail, by email or by WCES. Filing of a notice, ruling and decision in WCES is the official filing and start of any appeal or motion deadline. Parties registered in WCES for a claim will be sent a courtesy email informing the parties of a filing.

This rule is intended to implement Iowa Code sections 85.3 and 17A.12.

[ARC 8013B, IAB 7/29/09, effective 9/2/09; ARC 4568C, IAB 7/31/19, effective 7/10/19]

876—4.8(86) Filing of notice.

4.8(1) A contested case is commenced by filing the original notice and petition with the workers’ compensation commissioner. No action shall be taken by the workers’ compensation commissioner on any contested case against an adverse party unless the adverse party has answered or unless it can be shown by proper proof that the adverse party has been properly served. The original notice and petition if required by 876—4.6(85,86,17A) shall be accompanied by proof that the petitioner has deposited copies of such documents with the U.S. post office for delivery by certified mail, return receipt requested, upon the respondent or has submitted such copies to a proper person for delivery of personal service as in civil actions.

4.8(2) Filing fee.

a. For all original notices and petitions for arbitration or review-reopening relating to weekly benefits filed on account of each injury, gradual or cumulative injury, occupational disease or occupational hearing loss alleged, a filing fee shall be paid at the time of filing. The filing fee for petitions is $100. No filing fee is due for the filing of other actions where the sole relief sought is one of the following or a combination of any of them: medical and other benefits under Iowa Code section 85.27; burial benefits, Iowa Code section 85.28; determination of dependency, Iowa Code sections
85.42, 85.43, and 85.44; equitable apportionment, Iowa Code section 85.43; second injury fund, Iowa Code sections 85.63 to 85.69; vocational rehabilitation benefits, Iowa Code section 85.70(1); vocational training and education benefits, Iowa Code section 85.70(2); approval of legal, medical and other fees under Iowa Code section 86.39; commutation, Iowa Code sections 85.45 to 85.48; employee’s examination, Iowa Code section 85.39; employee’s examination or sanctions, Iowa Code section 85.39; application for alternate care, Iowa Code section 85.27; determination of liability, reimbursement for benefits paid and recovery of interest, Iowa Code section 85.21; interest, Iowa Code section 85.30; penalty, Iowa Code section 86.13; application for approval of third-party settlement, Iowa Code section 85.22; and petitions for declaratory orders or petitions for interventions filed pursuant to 876—Chapter 5. An amendment to a petition that was filed on or after July 1, 1988, that alleges an additional or alternate date of occurrence does not require payment of an additional filing fee if a filing fee was paid when the petition was filed.

b. A filing fee shall be required for each original notice and petition filed, as required in paragraph 4.8(2)“a.” If filing fees have been overpaid, the amount overpaid shall be refunded to the party who made the overpayment.

c. and d. Rescinded IAB 11/27/02, effective 1/1/03.

e. If the correct filing fee or fees are not paid at the time of filing of the original notice and petition, the workers’ compensation commissioner shall enter an order requiring payment of the correct filing fee or fees. If the required correction is not made by a date specified in the order, the original notice and petition shall automatically be dismissed without prejudice without entry of further order. See rule 876—4.36(86). If correction is made within the specified time, the initial filing shall be sufficient to have tolled the statute of limitations.

If no filing fee is paid at the time of filing of the original notice and petition, the workers’ compensation commissioner shall return the original notice and petition to the party filing it. Filing an original notice and petition without paying the fee shall not toll the statute of limitations. Tendering an amount less than required will be considered failure to pay a filing fee.

f. The filing fee may be taxed as a cost to the losing party in the case. If the filing fee would impose an undue hardship or be unjust in the circumstances for the losing party, the filing fee may be taxed as costs to the winning party in the case. If an original notice and petition is erroneously accepted for filing without payment of the correct filing fee or fees, any unpaid fees may be taxed as costs. See rule 876—4.33(86).

g. The filing fee shall be paid at the same time the petition is filed. The filing fee shall be paid electronically with a credit card or electronic check or by other electronic means as allowed by WCES. Checks should be made payable to the “Iowa Division of Workers’ Compensation.” If the payment of the filing fee is made by an insufficient funds check or a check on which payment is stopped or a check on which payment is otherwise not honored, it will be treated as a failure to pay the correct filing fee. See 4.8(2)“e.” Nonelectronic payment will not be accepted without an order granting permission for nonelectronic payment. Any statute of limitations is not tolled if a party has requested nonelectronic payment and is awaiting an order.

h. The workers’ compensation commissioner may accept for filing an original notice and petition without prepayment of the filing fee if in the discretion of the workers’ compensation commissioner the petitioner is unable to pay the fee at the time of filing. A deferral of payment of the filing fee shall only be granted upon written application by the petitioner. The application shall be filed at the same time the original notice and petition is filed. The application shall be in the form required by the workers’ compensation commissioner and shall include an affidavit signed by the petitioner. When payment of the filing fee is deferred, provisions for payment of the filing fee must be included in any settlement submitted to the workers’ compensation commissioner for approval or taxed as costs. When the application for deferral of payment of the filing fee is denied, the filing fee shall be paid as ordered. See 4.8(2)“e.” The form for the application deferral of prepayment of fees (Form No. 14-0075) shall not be filed using WCES. The document shall be filed in paper form. If the request for deferral of fees is granted, a claim will be established in WCES. Parties to the claim shall use WCES for future filings, unless a party has been excused from using WCES.
i. Rescinded IAB 1/29/97, effective 3/5/97.

j. Parties shall use the payment gateway in WCES to pay filing fees, unless an order has been issued allowing deferral of the payment of the filing fee or payment outside of WCES. In addition to the filing fee, the parties shall pay the convenience fee charged by the financial institution that is processing payment for WCES. This cost may be recoverable under rule 876—4.33(86).

This rule is intended to implement Iowa Code section 17A.12.

[ARC 7818B, IAB 6/3/09, effective 7/1/09; ARC 8013B, IAB 7/29/09, effective 9/2/09; ARC 3528C, IAB 12/20/17, effective 1/24/18; ARC 4568C, IAB 7/31/19, effective 7/10/19]

876—4.9(17A) Appearance and responses, pleadings, motions and settlements. Appearances and responses to pleadings and motions shall be made using the division of workers’ compensation’s WCES. Registration with the division of workers’ compensation’s WCES is required. Registration is accepted at efie.iowaworkcomp.gov. After a matter has been commenced and the respondent has been served with original notice and filed an answer or appearance, subsequent filings or submissions in WCES do not require proof of service to parties of record who are registered with WCES. Attorneys will need to use the AT pin or pro hac vice pin assigned by the Iowa Supreme Court to be associated with a case in WCES. When an attorney is not representing a party, the employer or insurance carrier or the employer’s or insurance carrier’s agent or claimant shall register in WCES to file the settlement or medical data pursuant to 876—subrule 3.1(2). The filer will receive a status update for the information the filer submits based upon the status the filer selects when registering in WCES.

4.9(1) Respondent—appearance. A respondent shall appear by filing an answer or a motion within 20 days after the service of the original notice and petition upon the respondent. A respondent shall file a response by answer or motion by using WCES for all claims in which a petition was filed within WCES unless permission has been granted to be excused from using WCES.

4.9(2) Motions. Motions attacking a pleading must be served before responding to a pleading or, if no responsive pleading is required, upon motion made by a party within 20 days after the service of the pleading on such party.

4.9(3) Pleading. Rescinded IAB 11/23/05, effective 1/1/06.

4.9(4) Time after motions attacking pleadings and special appearances. If a motion attacking a pleading is so disposed of as to require further pleading, such further pleading shall be served within ten days after notice of the action of the workers’ compensation commissioner or deputy workers’ compensation commissioner. If the further pleading requires a response, the response shall be filed within ten days after service of the further pleading.

4.9(5) Amendments to pleadings. A party may amend a pleading as a matter of course at any time before the party’s discovery is closed, or if no order is entered closing the party’s discovery, at any time before the case is assigned for hearing. Otherwise, a party may amend a pleading only by leave of the workers’ compensation commissioner or deputy workers’ compensation commissioner or by written consent of the adverse party. Leave to amend, including leave to amend to conform to proof, shall be freely given when justice so requires.

4.9(6) Form, submission and ruling on motions. All motions, including pre-answer motions and motions for summary judgment, shall have appended to them a concise memorandum brief and argument. All motions and applications except motions for summary judgment shall be deemed submitted without hearing on the record presented on the tenth day following filing. Motions for summary judgment shall be deemed submitted as provided in Iowa Rule of Civil Procedure 1.981. Resistances to motions shall have appended to them a concise memorandum brief and argument and shall be filed on or before the date of submission. Briefs and arguments are waived unless appended to the motion, application or resistance.

An order may be entered consolidating any motion for ruling with hearing of the contested case. Any party desiring a ruling on a motion prior to hearing may concisely set forth the necessity of prior ruling in the motion, application or resistance. If a pre-answer motion alleging lack of jurisdiction is overruled or consolidated with hearing of the contested case, the party shall plead to the merits and proceed to hearing of the contested case without submitting to the jurisdiction of the workers’ compensation commissioner.
If a motion attacking a pleading is consolidated with hearing of the contested case, the party shall respond to the pleading in the same manner as if the motion had been overruled.

4.9(7) **Consolidation.** Any party may file a motion to consolidate common questions of fact and law surrounding an injury or a series of injuries. The motion shall be deemed approved if no resistance to the motion is filed with the workers’ compensation commissioner within ten days of the filing of the motion. No order granting the motion will be filed by the workers’ compensation commissioner. As an alternative, the parties may make an oral motion to consolidate common questions of fact or law at the time of the pretrial hearing. A ruling on the motion will be included with the order issued from the pretrial hearing.

4.9(8) **Withdrawal of counsel.** Counsel may withdraw if another counsel has appeared or if the client’s written consent accompanies the withdrawal.

Under all other circumstances, counsel may withdraw only upon the order of the workers’ compensation commissioner after making written application. Counsel shall give the client written notice that the client has the right to object to the withdrawal by filing written objections and a request for a hearing to the Division of Workers’ Compensation, 1000 East Grand Avenue, Des Moines, Iowa 50319, when filing by mail, or 150 Des Moines Street, Des Moines, Iowa 50319, when filing in person, within ten days following the date the notice was mailed or personally delivered to the client. The client’s response does not need to be filed in WCES but may be mailed or delivered to the division. Counsel’s application shall be accompanied by proof that a copy of the application and notice was sent by certified mail addressed to the client’s last-known address or was delivered to the client personally. If no objections are timely filed, the withdrawal will become effective when approved by the workers’ compensation commissioner. If objections are timely filed, a hearing on the application will be held. No withdrawal under this subrule will be effective without the approval of the workers’ compensation commissioner. The filing of an application to withdraw stays all pending matters until a ruling is made on the application.

4.9(9) **Requests for default.** Requests or motions for default shall be as provided in Iowa Rules of Civil Procedure 1.971 to 1.977 except that entry of default shall be by order of the workers’ compensation commissioner or a deputy workers’ compensation commissioner.

4.9(10) **Pro hac vice.** An out-of-state attorney desiring to appear pro hac vice in an Iowa division of workers’ compensation case is required to access the office of professional regulation (OPR)/supreme court commissions (SCC) website, submit certain personal information to complete pertinent fields in the lawyer database, and pay a fee that will be deposited in the client security trust fund. The registration and fee payment allow the attorney to apply to appear pro hac vice in Iowa division of workers’ compensation cases, subject to the limits and requirements of Iowa Court Rule 31.14, for a period of up to five years from the date of registration. Attorneys who register and pay the fee appear in the OPR/SCC database with the status of “pro hac vice.” The Iowa division of workers’ compensation will request from the Iowa courts that a pro hac vice number be issued and will provide that number to the out-of-state attorney for registration with WCES. The affiliated in-state attorney shall file in WCES the application to appear pro hac vice completed by the out-of-state attorney using a pleading that is substantially similar to Iowa Court Rule 31.25—Form 1.

This rule is intended to implement the provisions of Iowa Code section 17A.12.

[ARC 3528C, IAB 12/20/17, effective 1/24/18; ARC 4568C, IAB 7/31/19, effective 7/10/19]

876—4.10(86,87) **Insurance carrier as a party.** Whenever any insurance carrier shall issue a policy with a clause in substance providing that jurisdiction of the employer is jurisdiction of the insurance carrier, the insurance carrier shall be deemed a party in any action against the insured.

This rule is intended to implement Iowa Code section 87.10.

876—4.11(86) **Signatures on documents and papers.** All documents and papers required by these rules, the Iowa Rules of Civil Procedure as applicable, or a statutory provision shall be signed by the party if unrepresented or the party’s attorney if represented. The party’s signature in addition to the attorney’s signature shall be necessary only when otherwise required by these rules, the Iowa Rules of
Civil Procedure as applicable, and any statutory provision. Iowa R. Elec. P. 16.305 concerning signatures is applicable to WCES.

This rule is intended to implement Iowa Code section 17A.12.

[ARC 4568C, IAB 7/31/19, effective 7/10/19]

876—4.12(86) Service on parties. Any document or paper not delivered under 876—4.6(85,86,17A) and 876—4.7(86,17A) which is to be filed, or which seeks relief from or action of or against another party, or which makes argument, or which has any significant effect on any contested case, shall be served on each party of record under 876—4.13(86).

This rule is intended to implement Iowa Code sections 17A.12 and 86.18.

876—4.13(86) Method of service. Except as provided in 876—4.6(85,86,17A) and 876—4.7(86,17A), service of all documents and papers to be served according to 876—4.12(86) and 876—4.18(85,86,17A) or otherwise upon a party represented by an attorney shall be made upon the attorney unless service upon the party is ordered by the workers’ compensation commissioner. Service upon the attorney or party shall be made using WCES once a party or party’s attorney has registered in WCES for the claim being contested. If a party has been allowed to not file with WCES or if a party or attorney has not appeared in WCES, service upon the attorney or party shall be made by delivery of a copy or mailing a copy to the last-known address of the attorney or party or, if no address is known, by filing a copy with the division of workers’ compensation. Delivery of a copy within this rule means: Handing it to the attorney or party; leaving it at the office of the attorney or party’s office or with the person in charge of the office; or if there is no one in charge of the office, leaving it in a conspicuous place in the office; or if the office is closed or the person to be served has no office, leaving it at the person’s dwelling house, or usual place of abode with some person of suitable age and discretion who is residing at the dwelling or abode. Service by mail under this rule is complete upon mailing. Documents that are served on a party for discovery and medical evidence under 876—4.14(86) and 876—4.18(17A,85,86) are not to be filed with the division of workers’ compensation. No documents or papers referred to in this rule shall be served by the workers’ compensation commissioner.

This rule is intended to implement Iowa Code sections 17A.12 and 86.18.

[ARC 4568C, IAB 7/31/19, effective 7/10/19]

876—4.14(86) Filing of documents and papers. All documents and papers required to be served on a party under rule 876—4.12(86) shall be filed with the workers’ compensation commissioner either before service or within a reasonable time thereafter. However, unless otherwise ordered by the workers’ compensation commissioner or deputy workers’ compensation commissioner, no deposition, notice of deposition, notice of service of interrogatories, interrogatories, request for production of documents, request for admission, notice of medical records and reports required to be served by 876—4.17(86), and answers and responses thereto shall be filed with or accepted for filing by the workers’ compensation commissioner unless its use becomes otherwise necessary in the action, in which case it shall be attached to the motion or response to motion requiring its use, or unless offered as evidence at hearing of the contested case.

This rule is intended to implement Iowa Code section 86.18.

876—4.15(86) Proof of service. Proof of service of all documents and papers to be served on another party under 876—4.12(86) shall be filed with the workers’ compensation promptly and, in any event, before action is to be taken thereon by the workers’ compensation commissioner or any party unless a responsive pleading has been filed. Proof shall be made by filing the document in WCES when another party is registered in WCES for that claim. If a party or a party’s attorney or representative is not in WCES for the claim being contested, the proof shall show the date and manner of service and may be by written acknowledgment of service, by certification of a member of the bar of this state, by affidavit
of the person who served the papers, or by any other proof satisfactory to the workers’ compensation commissioner.

This rule is intended to implement Iowa Code section 86.18.

[ARC 4568C, IAB 7/31/19, effective 7/10/19]

876—4.16(86) Request for copy. No person requesting a mailed file-stamped copy of a filing made in a contested case shall receive such a copy unless the request shall be accompanied by a self-addressed envelope with sufficient postage. In addition, no party requesting a file-stamped copy of a filing made by the party in a contested case shall receive such a copy unless the request shall be accompanied by sufficient copies to allow the requesting party to receive a copy.

This rule is intended to implement Iowa Code section 86.18.

876—4.17(17A,85,86) Service of records and reports. Each party to a contested case shall serve all records received pursuant to a patient’s waiver (Form 14-0043—authorization for release of information regarding claimants seeking workers’ compensation benefits) and medical records and reports concerning the injured worker in the possession of the party upon each opposing party not later than 20 days following filing of an answer or, if not then in possession of a party, within 10 days of receipt. Medical records and reports are records of medical practitioners and institutions concerning the injured worker. Medical practitioners and institutions are medical doctors, osteopaths, chiropractors, dentists, nurses, podiatrists, psychiatrists, psychologists, counselors, hospitals, clinics, persons engaged in physical or vocational rehabilitation or evaluation for rehabilitation, all other practitioners of the healing arts or sciences, and all other institutions in which the healing arts or sciences are practiced. Each party shall serve a notice accompanying the records and reports identifying the records and reports served by the name of the practitioner or institution or other source and date of the records and reports and, if served later than 20 days following filing of the answer, stating the date when the records and reports were received by the party serving them. Pursuant to 876—4.14(86), the notice and records and reports shall not be filed with the workers’ compensation commissioner. A party failing to comply with the provisions of this rule shall, if the failure is prejudicial to an opposing party, be subject to the provisions of 876—4.36(86). This rule does not require a party to serve any record or report that was previously served by another party in a contested case proceeding.

For hearings on or after July 1, 2004, compliance with this rule does not permit a record or report to be received into evidence if the record or report was not served prior to an applicable deadline established by rule or order for completing discovery or service of exhibits.

This rule is intended to implement Iowa Code sections 86.8 and 86.18.

876—4.18(17A,85,86) Medical evidence and discovery. Discovery in workers’ compensation proceedings is governed by the rules of civil procedure pursuant to 876—4.35(86). Any relevant medical record or report served upon a party in compliance with these rules prior to any deadline established by order or rule for service of the records and reports shall be admissible as evidence at hearing of the contested case unless otherwise provided by rule. Any party against which a medical record or report may be used shall have the right, at the party’s own initial expense, to cross-examine by deposition the medical practitioner producing the record or report and the deposition shall be admissible as evidence in the contested case.

This rule is intended to implement Iowa Code sections 86.8 and 86.18.

876—4.19(86) Prehearing procedure.

4.19(1) Prehearing procedure in contested cases shall be administered in accordance with these rules and the orders issued by the workers’ compensation commissioner or a deputy workers’ compensation commissioner.

4.19(2) Counsel of record and pro se litigants have a duty to exercise reasonable diligence to bring the contested case to hearing at the earliest reasonable opportunity.

4.19(3) For contested cases that were filed on or after July 1, 2004, the following time limits govern prehearing procedure, completion of discovery and case management in contested cases, except
proceedings under rules 876—4.46(17A,85,86) and 876—4.48(17A,85,86) and except when otherwise ordered by the workers’ compensation commissioner or a deputy workers’ compensation commissioner.

a. Within 120 days following filing of a petition, the counsel of record for all parties and all pro se litigants shall request a hearing by using WCES when this function is available to the public in WCES. In a case for which permission has been granted to be excused from using WCES, counsel of record for all parties and all pro se litigants shall jointly contact the hearing administrator by telephone at (515)725-3891 between the hours of 8:30 a.m. and 11 a.m. central time, Monday through Friday, excluding holidays, or by email at dwc.hearing@iwd.state.ia.us to schedule a hearing date, place and time. Claimant has primary responsibility for initiating the contact. The parties shall identify the case by file number and the names of the parties and request that the hearing be set at a specific date, place and time that is shown to be available on the hearing scheduler published on the division’s website. Primary and backup times must be requested for hearings in venues other than Des Moines. When the contact is made by email, a copy of the request shall be sent to each opposing party, and the hearing administrator will reply indicating whether or not the case is assigned at the time requested. If a request is denied, the parties shall continue to contact the hearing administrator by telephone or email until the case is scheduled or a prehearing conference is ordered. A joint scheduling contact may be initiated by any party at any other time agreeable to the parties. If more than 120 days have elapsed since the petition was filed, any party may move to schedule the hearing at a particular date, time and place that is available and the hearing administrator may assign the case for hearing at any date, time and place. The hearing date shall be within 12 months following the date the petition was filed or as soon thereafter as reasonably practicable as determined by the hearing administrator. If the parties fail to schedule the hearing with the hearing administrator, the case will be scheduled at the discretion of the hearing administrator without prior notice to the parties.

b. A party who intends to introduce evidence from an expert witness, including a rebuttal expert witness, shall certify to all other parties the expert’s name, subject matter of expertise, qualifications, and a summary of the expert’s opinions within the following time period: (1) claimant—120 days before hearing; (2) employer/second injury fund of Iowa—90 days before hearing; (3) rebuttal—60 days before hearing. Certification is not required to introduce evidence from an examining physician pursuant to Iowa Code section 85.39, a treating physician, or a vocational consultant if the expert witness is known by all parties to have personally provided services to the claimant and the witness’s reports are served on opposing parties prior to the date when certification is required. The parties may alter these times by written agreement.

c. Discovery responses must be supplemented as required in Iowa Rules of Civil Procedure 1.503(4) and 1.508(3). Discovery responses shall be supplemented within 20 days after a party requests supplementation. All discovery responses, depositions, and reports from independent medical examinations shall be completed and served on opposing counsel and pro se litigants at least 30 days before hearing. The parties may alter these times by written agreement.

d. At least 30 days before hearing, counsel of record and pro se litigants shall serve a witness and an exhibit list on all opposing counsel and pro se litigants and exchange all intended exhibits that were not previously required to be served. The witness list shall name all persons, except the claimant, who will be called to testify at the hearing or who will be deposed prior to the hearing in lieu of testifying at the hearing. The witness and exhibit lists are not filed in WCES. If the exhibit list does not contain actual exhibits, the exhibit list must specifically identify each exhibit in a way that permits the opposing party to recognize the exhibit. The description for a document should include the document’s date, number of pages and author or source. Exhibits that were specifically identified when served pursuant to rule 876—4.17(17A,85,86) or in a discovery response may be collectively identified by describing the service such as “exhibits described in the notices served pursuant to rule 876—4.17(17A,85,86) on May 7, June 11 and July 9, 2004.” Blanket references such as “all medical records,” “personnel file” or “records produced during discovery” do not specifically identify an exhibit. A party may serve a copy of the actual intended exhibits in lieu of an exhibit list. At least 14 days before hearing, counsel of record and pro se litigants shall file proposed exhibits in WCES or, if the counsel of record and pro se litigants are excused from using WCES, shall file the proposed exhibits with the division of workers’ compensation.
Counsel of record and pro se litigants shall file all written objections and motions to exclude evidence at least seven days before the hearing. Objections to exhibits are waived if they are not filed at least seven days before the hearing. Evidentiary depositions pursuant to Iowa Code section 86.18(2) may be taken at any time before the hearing in lieu of the witness testifying at the hearing.

e. If evidence is offered at hearing that was not disclosed in the time and manner required by these rules, as altered by order of the workers’ compensation commissioner or a deputy workers’ compensation commissioner or by a written agreement by the parties, the evidence will be excluded if the objecting party shows that receipt of the evidence would be unfairly prejudicial. Sanctions may be imposed pursuant to 876—4.36(86) in addition to or in lieu of exclusion if exclusion is not an effective remedy for the prejudice. If a party offers an exhibit or document in paper form which is accepted by the workers’ compensation commissioner or a deputy workers’ compensation commissioner, the party shall have five working days to submit an electronic copy of the document by using WCES.

f. At least 14 days before the hearing, counsel of record and pro se litigants shall prepare and file a joint hearing report that defines the claims, defenses, and issues that are to be submitted to the deputy commissioner who presides at the hearing. The hearing report shall be filed in Microsoft Word format as a proposed hearing report. After the hearing report is finalized at the hearing, the deputy commissioner or a party shall save and file the completed hearing report as a pdf or scanned document in WCES. The hearing report shall be signed by all counsel of record and pro se litigants and submitted to the deputy.

g. If a filer is unable to meet a nonjurisdictional filing deadline because of a technical failure in WCES, the filer must file the document using the earliest available electronic or nonelectronic means. The filing of the document will be accepted by the division of workers’ compensation as timely unless the commissioner or deputy commissioner determines that the untimely filing of the document should not be excused.

h. Jurisdictional deadlines, including but not limited to any applicable statute of limitations, cannot be extended. It is the filer’s responsibility to ensure that a document is filed timely to comply with jurisdictional deadlines. A technical failure, including a failure of WCES, will not excuse a failure to comply with a jurisdictional deadline.

i. A filer is not excused from missing a jurisdictional or nonjurisdictional filing deadline because of problems attributable to the filer (such as telephone line problems, problems with the filer’s Internet service provider, hardware problems, software problems, etc.).

[ARC 4568C; IAB 7/31/19, effective 7/10/19]

876—4.20(86) Prehearing conference. A deputy commissioner or the workers’ compensation commissioner may order parties in the case to either appear before the commissioner or a deputy commissioner for a conference, or communicate with the commissioner or the commissioner’s designee and with each other in any manner as may be prescribed to consider, so far as applicable to the particular case:

1. The necessity or desirability of amending pleadings by formal amendment or prehearing order;
2. Agreeing to admissions of facts, documents or records not really controverted, to avoid unnecessary proof;
3. Limiting the number of witnesses;
4. Settling any facts of which the commissioner or deputy commissioner is to be asked to take official notice;
5. Stating and simplifying the factual and legal issues to be determined;
6. Specifying the items and amounts of compensation claimed;
7. Specifying all proposed exhibits and proof thereof;
8. Consolidation, separation for hearing, and determination of points of law;
9. Specifying all witnesses expected to testify;
10. Possibility of settlement;
11. Filing of advance briefs, if any;
12. Setting or altering dates for completion of discovery or completion of medical evidence by each party;
13. Any other matter which may facilitate, expedite, or simplify any contested case. This rule is intended to implement Iowa Code sections 86.17 and 86.18.

876—4.21(86) Prehearing conference record. At the request of any attorney in the case, or at the discretion of a deputy commissioner or the workers’ compensation commissioner, the entire prehearing conference or any designated part thereof shall be recorded and the cost of the reporter shall be assessed to the requesting party, or if directed by the commissioner or deputy commissioner, assessed as costs.

This rule is intended to implement Iowa Code sections 86.17 and 86.18.

876—4.22(86) Orders. The deputy commissioner or workers’ compensation commissioner may enter an order reciting any action taken at the conference or pursuant to any other procedures prescribed which will control the subsequent course of action relative to matters which it includes, unless modified to prevent manifest injustice.

This rule is intended to implement Iowa Code sections 86.17 and 86.18.

876—4.23(86) Assignment for hearing. Contested cases shall be set for hearing within the discretion of the workers’ compensation commissioner as soon as practicable after the parties have had adequate opportunity to prepare for hearing. A party may request in writing that no hearing in a contested case be held until such time as specified matters have been accomplished or specified events have occurred. Continuances of hearings in contested cases shall be granted only by the workers’ compensation commissioner or the commissioner’s designee. Continuances are governed by Iowa Rules of Civil Procedure 1.910-1.912. Requests for continuance shall also state in detail the reasons for the request and whether the opposing party accedes to the request.

Defendants shall promptly notify the workers’ compensation commissioner of settlements.

This rule is intended to implement Iowa Code sections 86.8 and 86.18.

876—4.24(17A,86) Rehearing. Any party may file an application for rehearing of a proposed decision in any contested case by a deputy commissioner or a decision in any contested case by the workers’ compensation commissioner within 20 days after the issuance of the decision. If a party has been allowed to file not using WCES or a party to the claim is not in WCES, a copy of such application shall be timely mailed by the applicant to all parties of record not joining therein. An application for rehearing shall be deemed denied unless the deputy commissioner or workers’ compensation commissioner rendering the decision grants the application within 20 days after its filing. For purposes of this rule, motions or requests for reconsideration or new trial or retrial or any reexamination of any decision, ruling, or order shall be treated the same as an application for rehearing.

This rule is intended to implement Iowa Code chapters 17A, 85, 85A, 85B and 86.

[ARC 4568C, IAB 7/31/19, effective 7/10/19]

876—4.25(17A,86) Appeal when rehearing requested. An appeal to or review on motion of the workers’ compensation commissioner must be filed within 20 days after the application for rehearing of a proposed decision by a deputy workers’ compensation commissioner under 876—4.24(17A,86) has been denied or deemed denied or a decision on rehearing has been issued. If a notice of appeal is filed by one party and an application for rehearing is filed by a different party, the deputy retains jurisdiction to act on the application for rehearing, and the notice of appeal is stayed and deemed to have been filed on the day after the application for rehearing is denied or deemed denied or the decision on rehearing is issued.

This rule is intended to implement Iowa Code sections 17A.15, 17A.16 and 86.24.

876—4.26 Rescinded, effective July 1, 1977.

876—4.27(17A,86) Appeal. Except as provided in 876—4.2(86) and 876—4.25(17A,86), an appeal to the commissioner from a decision, order or ruling of a deputy commissioner in contested case proceedings shall be commenced within 20 days of the filing of the decision, order or ruling by filing a
notice of appeal with the workers’ compensation commissioner. If two or more contested cases were consolidated for hearing, a notice of appeal in one of the cases is an appeal of all the cases. The date the notice of appeal is filed shall be the date the notice of appeal is received by the agency. Miller v. Civil Constructors, 373 N.W.2d 115 (Iowa 1985). The notice shall be served on the opposing parties as provided in 876—4.13(86). An appeal shall be heard in Polk County or in any location designated by the workers’ compensation commissioner.

An interlocutory decision, order or ruling can be appealed only as hereinafter provided. A decision, order or ruling is interlocutory if, when issued, it does not dispose of all issues in the contested case that are ripe for adjudication. If the sole issue remaining for determination is claimant’s entitlement to additional compensation for unreasonable denial or delay of payment pursuant to Iowa Code section 86.13, the decision is not interlocutory. An adjudication that awards ongoing payments of weekly compensation under Iowa Code section 85.33 or 85.34(1) is not interlocutory. The workers’ compensation commissioner may, upon application from any party or on the commissioner’s own motion, and upon such terms as the commissioner orders, grant an appeal from an interlocutory decision, order or ruling if the commissioner finds that the ruling affects substantial rights, that the ruling will materially affect the final decision and that determination of the correctness of the ruling will better serve the interests of justice.

A cross-appeal may be taken under this rule or 876—4.25(17A,86) in the same manner as an appeal within the 20 days for the taking of an appeal or within 10 days after filing of the appeal, whichever is later.

This rule is intended to implement Iowa Code sections 17A.15 and 86.24.

876—4.28(17A,86) Briefing requirements on appeal. The commissioner shall decide an appeal upon the record submitted to the deputy workers’ compensation commissioner unless the commissioner is satisfied that there exists additional material evidence, newly discovered, which could not with reasonable diligence be discovered and produced at the hearing. A party must file a request for taking additional evidence within 20 days after the notice of appeal was filed. Any briefs required or allowed by this rule shall be filed promptly following service.

4.28(1) Time for serving briefs. Appellant shall serve its brief within 50 days after the date on which notice of appeal was filed, or within 20 days after filing of the hearing transcript, whichever date is later. Appellee shall serve its brief within 20 days after service of the brief of appellant. If appellant serves a reply brief, it shall be done within 10 days after service of appellee’s brief.

4.28(2) Cross-appeals. In the event of a cross-appeal, appellee (cross-appellant) shall serve its brief within 20 days after service of the brief of appellant. Appellant (cross-appellee) shall serve its responsive reply brief within 20 days after service of the brief of appellee. Appellee (cross-appellant) may serve a reply brief within 10 days after service of appellant’s reply brief. When more than one party appeals, the party filing the first notice of appeal will be designated the appellant and the party filing a subsequent notice of appeal will be designated the cross-appellant.

4.28(3) Multiple adverse parties. In cases involving multiple appeals involving multiple claimants, employers, insurance carriers or the second injury fund, the workers’ compensation commissioner shall enter an order establishing a briefing schedule.

4.28(4) Form of briefs. Respective briefs and exceptions on appeal shall include the following:
   a. Statement of the case.
   b. Statement of the issues on appeal.
   c. An argument corresponding to the separately stated issues and contentions of appellant with respect to the issues presented and reasons for them, with specific reference to the page or pages of the transcript which are material to the issues on appeal.
   d. A short conclusion stating the precise relief sought.

The appellee may submit a brief on appeal replying to the issues presented by the appellant, unless a cross-appeal is made in which case the brief of appellee shall contain the issues and argument involved in the cross-appeal as well as the response to the brief of appellant.

4.28(6) Extensions. One extension of up to 30 days will be granted if a motion to extend the time is served on or before the date service of the brief is required by this rule. A subsequent extension requires a motion showing good cause. The commissioner may grant a party the right to serve and file a brief after the time to do so has expired if the appeal or cross-appeal has not been dismissed or decided, the party moves for relief within 60 days from the date service of the brief was due, and the motion shows that the failure to timely serve the brief was due to a good cause that could not have been avoided through the exercise of reasonable diligence.

4.28(7) Issues considered on appeal. The appeal will consider the issues presented for review by the appellant and cross-appellant in their briefs and any issues necessarily incident to or dependent upon the issues that are expressly raised, except as provided in 876—4.29(86,17A). An issue will not be considered on appeal if the issue could have been, but was not, presented to the deputy. An issue raised on appeal is decided de novo and the scope of the issue is viewed broadly. If the ruling from which the appeal was taken made a choice between alternative findings of fact, conclusions of law, theories of recovery or defenses and the alternative selected in the ruling is challenged as an issue on appeal, de novo review includes reconsideration of all alternatives that were available to the deputy.

4.28(8) Sanctions. If an appellant’s brief or cross-appellant’s brief is not served and filed within the time required by this rule, including any extension, the party defending against the appeal or cross-appeal may move for dismissal. If an appellant’s brief or cross-appellant’s brief is not served within 30 days after the time required by these rules, including any extension, the workers’ compensation commissioner will notify the party in default that upon 15 days from service of the notification the appeal or cross-appeal will be dismissed for want of prosecution unless the default is remedied within that period. If the default is not remedied, the appeal or cross-appeal will be dismissed. If an appellee’s brief or cross-appellee’s brief is not served and filed, the appeal will be decided without reference to that brief.

This rule is intended to implement Iowa Code section 86.24.

[ARC 4568C, IAB 7/31/19, effective 7/10/19]

876—4.29(86,17A) Review upon motion. Except as provided in 876—4.25(17A,86) the commissioner may review the decision, order or ruling of a deputy commissioner in any contested case upon the commissioner’s own motion. Except as provided in 876—4.25(17A,86), the motion to review a decision, order or ruling in all contested cases must be filed within 20 days of the filing of the decision, order or ruling. The commissioner shall specify in a notice filed in WCES or mailed to the parties by certified mail, return receipt requested, on the date of filing of the motion the issues to be reviewed and the additional evidence, if any, to be obtained by the parties. The hearing under this rule shall be heard in Polk County or in any locality designated by the workers’ compensation commissioner.

This rule is intended to implement Iowa Code sections 17A.15 and 86.24.

[ARC 4568C, IAB 7/31/19, effective 7/10/19]

876—4.30(86,17A) Transcript on appeal or review. When an appeal to or review on motion of the commissioner is taken pursuant to 876—4.27(17A,86) or 876—4.29(86,17A), a transcript of the proceedings before the workers’ compensation commissioner shall be filed with the workers’ compensation commissioner within 30 days after the notice of the appeal is filed with the workers’ compensation commissioner. The appealing party shall bear the initial cost of transcription on appeal and shall pay the certified shorthand reporter or service for the transcript. In the event there is a cross-appeal, the appellant and cross-appellant shall share the cost of the transcript. In the event the cost of the transcript has been initially borne by a nonappealing party prior to appeal, the nonappealing party is entitled to reimbursement within 30 days after serving on the appealing party proof of the cost of the transcript. If not so reimbursed, the appeal may be dismissed.

This rule is intended to implement Iowa Code sections 17A.12, 17A.15, 86.19, 86.24 and 86.40.

876—4.31(86) Completion of contested case record. No evidence shall be taken after the hearing.

This rule is intended to implement Iowa Code section 86.18.
876—4.32(86,17A) Recording of proceedings. The workers’ compensation commissioner may arrange for the attendance of a certified shorthand reporter or mechanical means to record proceedings in contested cases. The workers’ compensation commissioner may require the defendant employer or on appeal to the commissioner, the appellant, to arrange for the attendance of a certified shorthand reporter or adequate mechanical means of recording the proceedings. The charges for attendance shall be paid initially to the certified shorthand reporter or service by the employer or on an appeal to the commissioner, the appellant. The charges shall be taxed as costs. The party initially paying the expense shall be reimbursed by the party taxed with the cost. If the expense is unpaid, it shall be paid by the party taxed with the cost.

This rule is intended to implement Iowa Code section 86.19.

876—4.33(86) Costs. Costs taxed by the workers’ compensation commissioner or a deputy commissioner shall be (1) attendance of a certified shorthand reporter or presence of mechanical means at hearings and evidential depositions, (2) transcription costs when appropriate, (3) costs of service of the original notice and subpoenas, (4) witness fees and expenses as provided by Iowa Code sections 622.69 and 622.72, (5) the costs of doctors’ and practitioners’ deposition testimony, provided that said costs do not exceed the amounts provided by Iowa Code sections 622.69 and 622.72, (6) the reasonable costs of obtaining no more than two doctors’ or practitioners’ reports, (7) filing fees when appropriate, including convenience fees incurred by using the WCES payment gateway, and (8) costs of persons reviewing health service disputes. Costs of service of notice and subpoenas shall be paid initially to the serving person or agency by the party utilizing the service. Expenses and fees of witnesses or of obtaining doctors’ or practitioners’ reports initially shall be paid to the witnesses, doctors or practitioners by the party on whose behalf the witness is called or by whom the report is requested. Witness fees shall be paid in accordance with Iowa Code section 622.74. Proof of payment of any cost shall be filed with the workers’ compensation commissioner before costs are taxed. The party initially paying the expense shall be reimbursed by the party taxed with the cost. If the expense is unpaid, it shall be paid by the party taxed with the cost. Costs are to be assessed at the discretion of the deputy commissioner or workers’ compensation commissioner hearing the case unless otherwise required by the Iowa Rules of Civil Procedure governing discovery.

This rule is intended to implement Iowa Code section 86.40.

[ARC 4568C, IAB 7/31/19, effective 7/10/19]

876—4.34(86) Dismissal for lack of prosecution. It is the declared policy that in the exercise of reasonable diligence, all contested cases before the workers’ compensation commissioner, except under unusual circumstances, shall be brought to issue and heard at the earliest possible time. To accomplish such purpose the workers’ compensation commissioner may take the following action:

4.34(1) Any contested case, where the original notice and petition is on file in excess of two years, may be subject to dismissal after the notice in 4.34(2) is sent to all parties and after the time as provided for in the notice.

4.34(2) After the circumstances provided in 4.34(1) occur, all parties to the action, or their attorneys, shall be sent notice from the division of workers’ compensation by certified mail containing the following:

a. The names of the parties;

b. The date or dates of injury involved in the contested case or appeal proceeding;

c. Counsel appearing;

d. Date of filing of the petition or appeal;

e. That the contested case proceeding will be dismissed without prejudice on the thirtieth day following the date of the notice unless good cause is shown why the contested case proceeding should not be dismissed.

4.34(3) The action or actions dismissed may at the discretion of the workers’ compensation commissioner and shall upon a showing that such dismissal was the result of oversight, mistake or other
reasonable cause, be reinstated. Applications for such reinstatement, setting forth the grounds, shall be filed within three months from the date of dismissal.

This rule is intended to implement Iowa Code sections 86.8, 17A.3(1) “b” and 86.18.

876—4.35(86) Rules of civil procedure. The rules of civil procedure shall govern the contested case proceedings before the workers’ compensation commissioner unless the provisions are in conflict with these rules and Iowa Code chapters 85, 85A, 85B, 86, 87 and 17A, or obviously inapplicable to the workers’ compensation commissioner. In those circumstances, these rules or the appropriate Iowa Code section shall govern. Where appropriate, reference to the word “court” shall be deemed reference to the “workers’ compensation commissioner” and reference to the word “trial” shall be deemed reference to “contested case hearing.”

This rule is intended to implement Iowa Code sections 17A.1, 17A.12, 17A.13, 17A.14, and 86.8.

876—4.36(86) Compliance with order or rules. If any party to a contested case or an attorney representing such party shall fail to comply with these rules or any order of a deputy commissioner or the workers’ compensation commissioner, the deputy commissioner or workers’ compensation commissioner may impose sanctions which may include dismissing the action without prejudice, excluding or limiting evidence, assessing costs or expenses, and closing the record in whole or in part to further activity by the party.

This rule is intended to implement Iowa Code section 86.8.

876—4.37(86,17A) Waiver of contested case provisions. The parties who wish to waive the contested case provisions of chapter 17A shall file a written stipulation of such waiver with the workers’ compensation commissioner before such waiver shall be recognized. The waiver shall specify the provisions waived such as a consent to delivery, waiver of original notice, or waiver of hearing.

This rule is intended to implement Iowa Code section 17A.10.

876—4.38(17A) Recusal.

4.38(1) The workers’ compensation commissioner, a chief deputy workers’ compensation commissioner or a deputy workers’ compensation commissioner shall withdraw from participation in the making of any proposed or final decision in a contested case if that person:
   a. Has a personal bias or prejudice concerning a party or a representative of a party;
   b. Has personally investigated, prosecuted or advocated in connection with that case the specific controversy underlying that case, another pending factually related contested case, or a pending factually related controversy that may culminate in a contested case involving the same parties;
   c. Is subject to the authority, direction or discretion of any person who has personally investigated, prosecuted or advocated in connection with that contested case, the specific controversy underlying that contested case, or a pending factually related contested case or controversy involving the same parties;
   d. Has acted as counsel to any person who is a private party to that proceeding within the past two years;
   e. Has a personal financial interest in the outcome of the case or any other significant personal interest that could be substantially affected by the outcome of the case;
   f. Has a spouse or relative within the third degree of relationship that (1) is a party to the case, or an officer, director or trustee of a party; (2) is a lawyer in the case; (3) is known to have an interest that could be substantially affected by the outcome of the case; or (4) is likely to be a material witness in the case;
   g. Has even the appearance of impropriety; or
   h. Has any other legally sufficient cause to withdraw from participation in the decision making in that case.

4.38(2) The term “personally investigated” means taking affirmative steps to interview witnesses directly or to obtain documents or other information directly. The term “personally investigated” does not include general direction and supervision of assigned investigators, unsolicited receipt of information
which is relayed to assigned investigators, review of another person’s investigative work product in the course of determining whether there is probable cause to initiate a proceeding, or exposure to factual information while performing other agency functions, including fact gathering for purposes other than investigation of the matter which culminates in a contested case. Factual information relevant to the merits of a contested case received by a person who later serves as presiding officer in that case shall be disclosed if required by Iowa Code section 17A.17 and rule 876—4.38(17A).

4.38(3) In a situation where the workers’ compensation commissioner, chief deputy workers’ compensation commissioner or deputy workers’ compensation commissioner knows of information which might reasonably be deemed to be a basis for recusal and decides voluntary withdrawal is unnecessary, that person shall submit the relevant information for the record by affidavit and shall provide for the record a statement of the reasons for the determination that withdrawal is unnecessary.

4.38(4) If a party asserts disqualification on any appropriate ground, including those listed in subrule 4.38(1), the party shall file a motion supported by an affidavit pursuant to Iowa Code section 17A.17(7). The motion must be filed as soon as practicable after the reason alleged in the motion becomes known to the party.

If, during the course of the hearing, a party first becomes aware of evidence of bias or other grounds for disqualification, the party may move for recusal but must establish the grounds by the introduction of evidence into the record.

If the workers’ compensation commissioner, chief deputy workers’ compensation commissioner or deputy workers’ compensation commissioner determines that recusal is appropriate, that person shall withdraw. If that person determines that withdrawal is not required, that person shall enter an order to that effect.

This rule is intended to implement Iowa Code section 17A.17.

876—4.39(17A,86) Filing by facsimile transmission (fax). When permission has been granted to be excused from using WCES, all documents filed with the agency pursuant to this chapter and Iowa Code section 86.24 except an original notice and petition requesting a contested case proceeding (see Iowa Code section 17A.12(9)) may be filed by facsimile transmission (fax). A copy shall be filed for each case involved. A document filed by fax is presumed to be an accurate reproduction of the original. If a document filed by fax is illegible, a legible copy may be substituted and the date of filing shall be the date the illegible copy was received. The date of filing by fax is the date the document is received by the agency. The agency will not provide a mailed file-stamped copy of documents filed by fax. The agency fax number is (515)281-6501.

This rule is intended to implement Iowa Code chapters 17A, 85, 85A, 85B and 86.

[ARC 4568C, IAB 7/31/19, effective 7/10/19]

876—4.40(73GA,ch1261) Dispute resolution. The workers’ compensation commissioner or the workers’ compensation commissioner’s designee (hereinafter collectively referred to as the workers’ compensation commissioner) shall have all power reasonable and necessary to resolve contested cases filed under Chapter 4 of these rules. This power includes, but is not limited to, the following: the power to resolve matters pursuant to initiation of mandatory dispute resolution proceedings by the workers’ compensation commissioner; the power to resolve matters pursuant to a request by the parties; the power to impose sanctions; and the power to require conduct by the parties. However, no issue in a contested case may be finally resolved under this rule without consent of the parties.

An employee of the division of workers’ compensation who has been involved in dispute resolution shall not be a witness in any contested case proceeding under this chapter.

4.40(1) Mandatory proceedings. The workers’ compensation commissioner may require that the parties participate in dispute resolution in the following situation:
   a. The oldest one-fourth of contested cases which are not scheduled for hearing.
   b. All cases where discovery deadlines have been set pursuant to a prehearing order and the deadlines have passed.
   c. All cases where the principal dispute is medical benefits.
d. All cases where the only dispute is the extent of disability.

e. All cases involving liability disputes of alleged workers’ compensation insurance carriers and alleged employers pursuant to Iowa Code section 85.21.

f. Equitable apportionment of compensation payments pursuant to Iowa Code section 85.43.

g. All cases where the workers’ compensation commissioner determines that dispute resolution would be in the best interest of the parties.

4.40(2) Voluntary proceedings. The parties may voluntarily agree to submit to dispute resolution.

4.40(3) The parties must comply with the good faith requirements of rule 876—10.1(17A,85,86) before requesting a voluntary proceeding pursuant to subrule 4.40(2).

4.40(4) See 876—subrule 10.1(5) regarding informal dispute resolution.

4.40(5) Rescinded IAB 9/14/94, effective 10/19/94.

This rule is intended to implement Iowa Code sections 17A.10, 86.8 and 86.13 and 1990 Iowa Acts, chapter 1261, section 3.


876—4.43(17A,85,86) Summary trial. Rescinded IAB 9/14/94, effective 10/19/94.


876—4.45(17A,86) Length of briefs. Except by permission of the presiding deputy workers’ compensation commissioner or by permission of the workers’ compensation commissioner when an appeal pursuant to rule 876—4.27(17A,86) has been filed, principal briefs shall not exceed 50 Arabic-numbered pages. Reply briefs shall not exceed 25 Arabic-numbered pages. Permission may be granted ex parte. In the event of a cross-appeal, appellant’s (cross-appellee’s) responsive reply brief shall be considered a principal brief. The type used shall not be smaller than pica type and each line shall contain an average of no more than 60 characters. If a brief is submitted in excess of the length allowed in this rule, the portion exceeding the allowable length will not be considered. This rule does not prohibit a presiding deputy workers’ compensation commissioner or the workers’ compensation commissioner from limiting the length of a brief. An exception to this rule is the length of briefs (three pages) in an application for alternate care. See subrule 4.48(11).

This rule is intended to implement Iowa Code sections 17A.12, 17A.15, 86.8, 86.18 and 86.24.

876—4.46(17A,85,86) Contested case proceedings—health service disputes.

4.46(1) See rule 876—10.3(17A,85,86) for informal resolution procedures and definitions. The following definition also applies to this rule:

“Petitioning party” means the person who requests or initiates a contested case proceeding.

4.46(2) If utilization of the procedures given in rule 876—10.3(17A,85,86) does not resolve the dispute and the parties have complied with the good faith requirements of rule 876—10.1(17A,85,86), a contested case may be initiated. The procedures given in rule 876—10.3(17A,85,86) must be used prior to initiation of a contested case. The provider or the responsible party that is unwilling to accept the determination of the person making a determination after reviewing the dispute as provided in rule 876—10.3(17A,85,86) shall initiate the contested case proceeding. The proceeding shall be initiated as provided in this chapter and Iowa Code chapter 17A and shall follow the provisions of this rule. The proceeding must be initiated within 30 days of the date of the determination made pursuant to rule 876—10.3(17A,85,86). If a contested case proceeding is not initiated or is not initiated within the time provided in this rule, the allowed amount of the charge by the provider shall be the amount determined pursuant to rule 876—10.3(17A,85,86).

4.46(3) The evidence submitted in the contested case proceeding shall be limited to the evidence submitted pursuant to rule 876—10.3(17A,85,86) and a copy of the determination made pursuant to
rule 876—10.3(17A,85,86). This evidence shall be filed by the party requesting the contested case proceeding at the time the contested case proceeding is initiated. However, the workers’ compensation commissioner may request that additional evidence be submitted or may grant submission of additional evidence if the commissioner is satisfied that there exists additional material evidence, newly discovered, which could not with reasonable diligence be discovered and produced pursuant to rule 876—10.3(17A,85,86). The issues of the contested case proceeding shall be limited to the dispute considered in rule 876—10.3(17A,85,86).

4.46(4) The petitioning party has the burden of proof.

4.46(5) If the petitioning party wishes to file a brief, it must be filed with the request for contested case proceeding.

4.46(6) The opposing party must file a response within 30 days of the date of service of the request for contested case proceeding.

4.46(7) If the opposing party wishes to file a brief, it must be filed with the response.

4.46(8) Sixty days after the request for contested case is filed with the workers’ compensation commissioner, the workers’ compensation commissioner will review the matter. The notice of the review to the parties shall be the provisions of this rule and no other notice will be given.

4.46(9) The workers’ compensation commissioner shall review the matter and make a decision as soon as practicable after the review. The decision shall be as provided in this chapter and Iowa Code chapter 17A.

This rule is intended to implement Iowa Code sections 17A.10, 17A.12, 17A.14, 85.27, 86.8 and 86.39.


876—4.48(17A,85,86) Application for alternate care.

4.48(1) Effective date. This rule is effective for applications for alternate care received on or after July 1, 1992.

4.48(2) Purpose. The purpose of this rule is to establish the procedures for issuing decisions on applications for alternate care within the time provided in Iowa Code section 85.27.

4.48(3) Definitions. The following definitions apply to this rule:

“Application for alternate care,” hereinafter referred to as “application,” shall mean a contested case proceeding filed with the workers’ compensation commissioner which requests alternate care pursuant to Iowa Code section 85.27.

“Employer” means the person who is liable for payment of medical services provided pursuant to the Iowa workers’ compensation laws and includes an employer, an employer who has been relieved from insurance pursuant to Iowa Code section 87.11, and an insurance carrier which provides an employer workers’ compensation insurance.

“Proper application” means an application for alternate care that complies with the requirements of this rule.

4.48(4) Dissatisfaction—basis. Prior to filing the application the employee must communicate the basis of dissatisfaction of the care to the employer.

4.48(5) Application. The application shall: be filed on the form provided by the workers’ compensation commissioner; concern only the issue of alternate care; state the reasons for the employee’s dissatisfaction with the care chosen by the employer; be served on the employer; contain proof of service on the employer; and specify whether a telephone or in-person hearing is requested.

4.48(6) Fee. No filing fee is due. See 4.8(2) “a.”

4.48(7) Employer liability. Application cannot be filed under this rule if the liability of the employer is an issue. If an application is filed where the liability of the employer is an issue, the application will be dismissed without prejudice. (Petitions for alternate care where liability of the employer is an issue should be filed pursuant to rule 876—4.1(85,85A,85B,86,87,17A).)
4.48(8) Notice of hearing. The workers’ compensation commissioner will notify the parties by ordinary mail, by facsimile transmission (fax) or by WCES of the time, place and nature of hearing. No notice will be made until a proper application is received by the workers’ compensation commissioner. The notice will specify whether the hearing will be by telephone, in person or by other digital means.

4.48(9) Discovery and evidence. All discovery must be completed prior to the contested case hearing. See subrule 4.48(10) on motions on discovery matters. Any written evidence to be used by the employer or the employee must be exchanged prior to the hearing. All written evidence must be filed with the agency before the date of the hearing. Written evidence shall be limited to ten pages per party.

4.48(10) Motions. All motions except as provided in this subrule will be considered at the hearing. A timely motion to change the type of hearing (telephone or in-person) may be considered prior to the hearing. The workers’ compensation commissioner will make no rulings on discovery matters or motions.

4.48(11) Briefs. Hearing briefs, if any, must be filed with the agency before the date of the hearing and shall be limited to three pages.

4.48(12) Hearing. The hearing will be held by telephone, in person or by other digital means in Des Moines, Iowa. The employer shall have the right to request an in-person hearing if the employee has requested a telephone hearing in the application. The employer shall or the record respond to the allegations contained in the application. The hearing will be electronically recorded. If there is an appeal of a proposed decision or judicial review of final agency action, the appealing party is responsible for filing a transcript of the hearing.

Copies of the recording will be provided to the parties. A transcript shall be provided by the appealing party pursuant to Iowa Code section 86.24(4) and a copy thereof shall be served on the opposing party at the time the transcript is filed with the workers’ compensation commissioner unless the parties submit an agreed-upon transcript. If a party disputes the accuracy of any transcript prepared by the opposing party, that party shall submit its contentions to the workers’ compensation commissioner for resolution. Any transcription charges incurred by the workers’ compensation commissioner in resolving the dispute shall be initially paid pursuant to Iowa Code section 86.19(1) by the party who disputes the accuracy of the transcript prepared by the appellant.

4.48(13) Represented party. A party may be represented as provided in Iowa Code section 631.14. The presiding deputy may permit a party who is a natural person to be assisted during a hearing by any person who does so without cost to that party if the assistance promotes full and fair disclosure of the facts or otherwise enhances the conduct of the hearing. The employer and its insurance carrier shall be treated as one party unless their interests appear to be in conflict and a representative of either the employer or its insurance carrier shall be deemed to be a representative of both unless notice to the contrary is given.

4.48(14) Decision. A decision will be issued within 10 working days of receipt of a proper application when a telephone hearing is held or within 14 working days of receipt of a proper application when an in-person hearing is held.

This rule is intended to implement Iowa Code sections 17A.12, 85.27, 86.8 and 86.17.

[ARC 4568C, IAB 7/31/19, effective 7/10/19]

876—4.49(17A,85,86) Method of holding hearing. Any hearing held under this chapter may be by voice or video technology including but not limited to Internet-based video.

This rule is intended to implement Iowa Code sections 17A.12, 85.27, 86.8, 86.17 and 86.18.

876—4.50(85) Vocational training, education, and supplies.

4.50(1) Purpose. The purpose of this rule is to establish the procedures for issuing decisions on applications for vocational training, education, and supplies provided for in Iowa Code section 85.70(2).

4.50(2) Definitions. The following definitions apply to this rule:

“Application for vocational training and education hearing” or “application” means a contested case proceeding filed with the division of workers’ compensation contesting the results of an evaluation and determination or contesting or requesting the termination of a vocational training and education program.
“Evaluation and determination” means an assessment conducted by the department of workforce development to determine if the employee would benefit from a vocational training and education program offered through an area community college to allow the employee to return to the workforce.

“Request for vocational training and education” or “request” means a written request for an evaluation and determination of whether an employee is entitled to vocational training, education, and supplies.

“Vocational training and education” shall include general educational development programs for employees who have not graduated from high school or obtained a general education diploma, and career and technical education programs that provide instruction in the areas of agriculture, family and consumer sciences, health occupations, business, industrial technology, and marketing, offered through an area community college that will allow the employee to return to the workforce.

4.50(3) Application for vocational training and education.
   a. An application shall:
      (1) Only concern the issue of vocational training, education, and supplies;
      (2) Be filed on the form provided by the division of workers’ compensation;
      (3) State the reasons for the application;
      (4) Be served on the other party;
      (5) Contain a proof of service on the other party; and
      (6) Specify whether a telephone or in-person hearing is requested.
   b. An application for vocational training and education must be filed in WCES unless permission has been granted to file paper documents. Applicant(s) must serve a copy of this form on the appellee(s) by certified mail, return receipt requested, or by personal service as in civil actions in accordance with rule 876—4.7(86,17A) and mail a copy to the attorney of record for the appellee(s), if known, in accordance with rule 876—4.13(86).

4.50(4) Fee. No filing fee is due. See paragraph 4.8(2) “a.”

4.50(5) Request for vocational education and training. Prior to filing an application, the employee shall complete a request on a form supplied by the department of workforce development and submit the completed form to the department of workforce development asking for an evaluation and determination. The employee, employer, or insurance carrier may contest the results of the evaluation and determination by filing an application with the division of workers’ compensation.

4.50(6) Proper application. An application may not be filed under this rule until:
   a. An evaluation and determination has been made by the department of workforce development; and
   b. There has been a finding by the division of workers’ compensation or the employer or the employer’s insurance carrier or both and the employee agree that the employee has sustained an injury to the shoulder resulting in a permanent partial disability for which compensation is payable under Iowa Code section 85.34(2) “n.” and the employee cannot return to gainful employment because of such disability.

4.50(7) Notice of hearing. The workers’ compensation commissioner shall notify the parties by electronic mail, ordinary mail, or facsimile of the time, place, and nature of the hearing. No notice will be made until a proper application is received by the workers’ compensation commissioner. The notice shall specify whether the hearing will be held by telephone or in person.

4.50(8) Evidence. Any written evidence to be used by the employer, the employer’s insurance carrier, or the employee must be exchanged prior to the hearing. All written evidence must be filed with the agency before the date of hearing. Written evidence shall be limited to 50 pages per party.

4.50(9) Motion to change hearing type. A timely motion to change the type of hearing (telephone or in-person) may be considered prior to the hearing. The workers’ compensation commissioner will make no rulings on motions.

4.50(10) Briefs. Hearing briefs, if any, must be filed with the agency before the date of the hearing and shall be limited to five pages.

4.50(11) Hearing. The hearing will be held either by telephone or in person in Des Moines, Iowa. If the party filing the application does not request an in-person hearing in the application, the other
parties may request an in-person hearing. The hearing will be recorded electronically. Copies of the recording will be provided to the parties. If there is an appeal of a proposed decision or judicial review of final agency action, the appealing party is responsible for filing a transcript of the hearing. A transcript shall be provided by the appealing party pursuant to Iowa Code section 86.24(4) and a copy of the transcript shall be served on the opposing party at the time the transcript is filed with the workers’ compensation commissioner, unless the parties submit an agreed-upon transcript. If a party disputes the accuracy of any transcript prepared by the opposing party, that party shall submit its contentions to the workers’ compensation commissioner for resolution. Any transcription charges incurred by the workers’ compensation commissioner in resolving the dispute shall be initially paid by the party that disputes the accuracy of the transcript, pursuant to Iowa Code section 86.19(1).

4.50(12) Represented party. A party may be represented as provided in Iowa Code section 631.14. The presiding deputy may permit a party who is a natural person to be assisted during a hearing by any person who does so without cost to that party if the assistance promotes full and fair disclosure of the facts or otherwise enhances the conduct of the hearing. The employer and the employer’s insurance carrier shall be treated as one party unless their interests appear to be in conflict, and a representative of either the employer or the employer’s insurance carrier shall be deemed to be a representative of both unless notice to the contrary is given.

4.50(13) Decision. A decision will be issued within 30 working days of receipt of a proper application.

This rule is intended to implement Iowa Code sections 17A.12, 85.70(2), and 86.17.

[ARC 3528C, IAB 12/20/17, effective 1/24/18; ARC 4568C, IAB 7/31/19, effective 7/10/19]

876—4.51(86) Agency notice of judicial review matters. A party who petitions for judicial review is responsible for filing with the division of workers’ compensation’s WCES a copy of the petition for judicial review within ten days of filing the petition with a district court. A party shall also file a copy of each appellate court decision within ten days of the date the appellate court decision was issued and filed. Within 45 days of the filing of the final appellate court decision, the same party shall notify the division of workers’ compensation of the result of the appellant process.

This rule is intended to implement Iowa Code chapters 17A, 85, 85A, 85B and 86.

[ARC 4568C, IAB 7/31/19, effective 7/10/19]

876—4.52(86) Rules of electronic procedure. Chapter 16 of the Iowa Court Rules of Electronic Procedure shall govern the use and filings in WCES for contested case proceedings before the workers’ compensation commissioner unless the provisions are in conflict with these rules and Iowa Code chapters 85, 85A, 85B, 86, 87 and 17A or obviously inapplicable to the workers’ compensation commissioner. In those circumstances, these rules or the appropriate Iowa Code section shall govern. Where appropriate, reference to the word “court” shall be deemed reference to the “workers’ compensation commissioner or deputy workers’ compensation commissioner,” reference to the word “trial” shall be deemed reference to “contested case hearing,” and reference to “clerk of court” shall be deemed reference to staff at the division of workers’ compensation.

This rule is intended to implement Iowa Code chapters 17A, 85, 85A, 85B and 86.

[ARC 4568C, IAB 7/31/19, effective 7/10/19]

[Emergency filed and effective 9/29/75—published 10/6/75]
[Filed 11/17/75, Notice 10/6/75—published 12/1/75, effective 1/5/76]
[Filed emergency 6/25/76—published 7/12/76, effective 7/1/76]
[Filed emergency 6/10/77—published 6/29/77, effective 7/1/77]
[Filed 8/3/77, Notice 6/29/77—published 8/24/77, effective 9/28/77]
[Filed 5/7/80, Notice 3/19/80—published 5/28/80, effective 7/2/80]
[Filed 9/26/80, Notice 8/20/80—published 10/15/80, effective 11/19/80]
[Filed 4/8/82, Notice 3/3/82—published 4/28/82, effective 6/2/82]
[Filed emergency 6/18/82—published 7/7/82, effective 7/1/82]
[Filed 3/21/85, Notice 1/2/85—published 4/10/85, effective 5/15/85]
[Filed 9/4/85, Notice 7/31/85—published 9/25/85, effective 10/30/85]
[Filed emergency 6/24/86—published 7/16/86, effective 7/1/86]
[Filed emergency 6/26/86—published 7/16/86, effective 7/1/86]
[Filed 6/26/86, Notice 5/21/86—published 7/16/86, effective 8/20/86]
[Editorially transferred from [500] to [343] IAC Supp. 9/24/86]
[Filed emergency 12/11/86—published 12/31/86, effective 12/11/86]
[Filed 5/27/87, Notice 4/22/87—published 6/17/87, effective 7/22/87]
[Filed emergency 6/23/88—published 7/13/88, effective 7/1/88]
[Filed 6/29/89, Notice 5/31/89—published 7/26/89, effective 8/30/89]
[Filed emergency 8/31/89—published 9/20/89, effective 9/1/89]
[Filed 11/9/89, Notice 9/20/89—published 11/29/89, effective 1/3/90]
[Filed emergency 6/19/90—published 7/11/90, effective 7/1/90]
[Filed 1/16/91, Notice 7/11/90—published 2/6/91, effective 3/13/91]
[Filed 2/15/91, Notice 12/26/90—published 3/6/91, effective 4/10/91]
[Filed emergency 6/5/92—published 6/24/92, effective 7/1/92]
[Filed emergency 6/19/92—published 7/8/92, effective 7/1/92]
[Filed 8/13/92, Notice 6/24/92—published 9/2/92, effective 10/7/92]
[Filed 8/13/92, Notice 7/8/92—published 9/2/92, effective 10/7/92]
[Filed emergency 6/3/94—published 6/22/94, effective 7/1/94]
[Filed 8/26/94, Notice 7/20/94—published 9/14/94, effective 10/19/94]
[Filed 1/13/95, Notice 12/7/94—published 2/1/95, effective 3/8/95]
[Filed 1/10/97, Notice 12/4/96—published 1/29/97, effective 3/5/97]
[Filed emergency 7/1/98—published 7/29/98, effective 7/1/98]
[Filed 5/12/00, Notice 4/5/00—published 5/31/00, effective 7/5/00]
[Filed 2/15/02, Notice 1/9/02—published 3/6/02, effective 4/10/02]
[Filed 4/12/02, Notice 3/6/02—published 5/1/02, effective 7/1/02]
[Filed 10/29/02, Notice 9/18/02—published 11/27/02, effective 1/1/03]
[Filed emergency 12/16/02—published 1/8/03, effective 1/1/03]
[Filed 7/1/03, Notice 1/8/03—published 7/23/03, effective 8/27/03]
[Filed emergency 7/1/04—published 7/21/04, effective 7/1/04]
[Filed 8/27/04, Notice 7/21/04—published 9/15/04, effective 10/20/04]
[Filed 10/21/04, Notice 9/15/04—published 11/10/04, effective 1/1/05]
[Filed 11/4/05, Notice 9/14/05—published 11/23/05, effective 1/1/06]
[Filed 10/5/06, Notice 8/30/06—published 10/25/06, effective 11/29/06]
[Filed emergency 6/15/07—published 7/18/07, effective 7/1/07]
[Filed 9/6/07, Notice 7/18/07—published 9/26/07, effective 10/31/07]
[Filed Emergency ARC 7818B, IAB 6/3/09, effective 7/1/09]
[Filed ARC 8013B (Notice ARC 7819B, IAB 6/3/09), IAB 7/29/09, effective 9/2/09]
[Filed ARC 3528C (Notice ARC 3414C, IAB 10/25/17), IAB 12/20/17, effective 1/24/18]
[Filed Emergency After Notice ARC 4568C (Notice ARC 4472C, IAB 6/5/19), IAB 7/31/19, effective 7/10/19]
CHAPTER 5
DECLARATORY ORDERS
[Prior to 9/24/86 see Industrial Commissioner[500]]
[Prior to 1/29/97 see Industrial Services Division[343]]
[Prior to 7/29/98 see Industrial Services Division[873][Ch 5]

876—5.1(17A) Petition for declaratory order. Any person may file a petition with the workers’ compensation commissioner for a declaratory order as to the applicability to specified circumstances of a statute, rule, or order within the primary jurisdiction of the workers’ compensation commissioner, at the office of the workers’ compensation commissioner. Parties shall not use WCES for declaratory order proceedings. A petition is deemed filed when it is received by that office. The workers’ compensation commissioner shall 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:

BEFORE THE WORKERS’ COMPENSATION COMMISSIONER

Petition by (Name of Petitioner) for a Declaratory Order on (Cite provisions of law involved).

PETITION FOR DECLARATORY ORDER

The petition must provide the following information:
1. A clear and concise statement of all relevant facts on which the order is requested.
2. A citation and the relevant language of the specific statutes, rules, policies, decisions, or orders, whose applicability is questioned, and any other relevant law.
3. The questions petitioner wants answered, stated clearly and concisely.
4. The answers to the questions desired by the petitioner and a summary of the reasons urged by the petitioner in support of those answers.
5. The reasons for requesting the declaratory order and disclosure of the petitioner’s interest in the outcome.
6. A statement indicating whether the petitioner is currently a party to another proceeding involving the questions at issue and whether, to the petitioner’s knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity.
7. The names and addresses of other persons, or a description of any class of persons, known by petitioner to be affected by, or interested in, the questions presented in the petition.
8. Any request by petitioner for a meeting provided for by rule 876—5.7(17A).

The petition must be dated and signed by the petitioner or the petitioner’s representative. It must also include the name, mailing address, and telephone number of the petitioner and petitioner’s representative and a statement indicating the person to whom communications concerning the petition should be directed.

[ARC 4568C, IAB 7/31/19, effective 7/10/19]

876—5.2(17A) Notice of petition. Within five working days after receipt of a petition for a declaratory order, the workers’ compensation commissioner shall give notice of the petition to all persons not served by the petitioner pursuant to rule 876—5.6(17A) to whom notice is required by any provision of law. The workers’ compensation commissioner may also give notice to any other persons.

876—5.3(17A) Intervention.

5.3(1) Nondiscretionary intervention. Persons who qualify under any applicable provision of law as an intervenor and who file a petition for intervention within 15 working days of the filing of a petition for declaratory order and before 30-day time for agency action under rule 876—5.8(17A) shall be allowed to intervene in a proceeding for a declaratory order.
5.3(2) Discretionary intervention. Any person who files a petition for intervention at any time prior to the issuance of an order may be allowed to intervene in a proceeding for a declaratory order at the discretion of the workers’ compensation commissioner.

5.3(3) Filing and form of petition for intervention. A petition for intervention shall be filed at the office of the workers’ compensation commissioner. Such a petition is deemed filed when it is received by that office. The workers’ compensation commissioner will provide the petitioner with a file-stamped copy of the petition for intervention if the petitioner provides an extra copy for this purpose. A petition for intervention must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

BEFORE THE WORKERS’ COMPENSATION COMMISSIONER

Petition by (Name of Original Petitioner)
for a Declaratory Order on (Cite provisions
of law cited in Original Petition).
Petition for intervention by (Name of
Intervenor).

{ PETITION FOR INTERVENTION }

The petition for intervention must provide the following information:
1. Facts supporting the intervenor’s standing and qualifications for intervention.
2. The answers urged by the intervenor to the question or questions presented and a summary of the reasons urged in support of those answers.
3. Reasons for requesting intervention and disclosure of the intervenor’s interest in the outcome.
4. A statement indicating whether the intervenor is currently a party to any proceeding involving the questions at issue and whether, to the intervenor’s knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity.
5. The names and addresses of any additional persons, or a description of any additional class of persons, known by the intervenor to be affected by, or interested in, the questions presented.
6. Whether the intervenor consents to be bound by the determination of the matters presented in the declaratory order proceeding.

The petition must be dated and signed by the intervenor or the intervenor’s representative. It must also include the name, mailing address, and telephone number of the intervenor and intervenor’s representative, and a statement indicating the person to whom communications should be directed.

876—5.4(17A) Briefs. The petitioner or any intervenor may file a brief in support of the position urged. The workers’ compensation commissioner may request a brief from the petitioner, any intervenor, or any other person concerning the questions raised.

876—5.5(17A) Inquiries. Inquiries concerning the status of a declaratory order proceeding may be made to the Workers’ Compensation Commissioner, 1000 E. Grand, Des Moines, Iowa 50319-0209.

876—5.6(17A) Service and filing of petitions and other papers.

5.6(1) Service. Except where otherwise provided by law, every petition for declaratory order, petition for intervention, brief, or other paper filed in a proceeding for a declaratory order shall be served upon each of the parties of record to the proceeding, and on all other persons identified in the petition for declaratory order or petition for intervention as affected by or interested in the questions presented, simultaneously with their filing. The party filing a document is responsible for service on all parties and other affected or interested persons. All documents filed shall indicate all parties or other persons served and the date and method of service.

5.6(2) Filing. All petitions for declaratory orders, petitions for intervention, briefs, or other papers in a proceeding for a declaratory order shall be filed with the Workers’ Compensation Commissioner, 1000 E. Grand, Des Moines, Iowa 50319, when filed by mail, or 150 Des Moines Street, Des Moines, Iowa 50319, when filed in person.
5.6(3) Method of service, time of filing, and proof of service. Method of service and proof of service shall be as provided by rules 876—4.13(86) and 876—4.15(86). All documents are considered filed when received by the agency.

[ARC 3528C, IAB 12/20/17, effective 1/24/18]

876—5.7(17A) Consideration. Upon request by petitioner, the workers’ compensation commissioner must schedule a brief and informal meeting between the original petitioner, all intervenors, and the workers’ compensation commissioner or a member of the staff of the workers’ compensation commissioner to discuss the questions raised. The workers’ compensation commissioner may solicit comments from any person on the questions raised. Also, comments on the questions raised may be submitted to the workers’ compensation commissioner by any person.

876—5.8(17A) Action on petition.

5.8(1) Time frames for action. Within 30 days after receipt of a petition for a declaratory order, the workers’ compensation commissioner or the commissioner’s designee shall take action on the petition as required by Iowa Code section 17A.9(5).

5.8(2) Date of issuance of order. The date of issuance of an order or of a refusal to issue an order is the date the order or refusal is filed unless another date is specified in the order.

876—5.9(17A) Refusal to issue order.

5.9(1) The workers’ compensation commissioner shall not issue a declaratory order where prohibited by Iowa Code section 17A.9(1), and may refuse to issue a declaratory order on some or all questions raised for the following reasons:

1. The petition does not substantially comply with the required form.
2. The petition does not contain facts sufficient to demonstrate that the petitioner will be aggrieved or adversely affected by the failure of the workers’ compensation commissioner to issue an order.
3. The workers’ compensation commissioner does not have jurisdiction over the questions presented in the petition.
4. The questions presented by the petition are also presented in a current rule making, contested case, or other agency or judicial proceeding, that may definitively resolve them.
5. The questions presented by the petition would more properly be resolved in a different type of proceeding or by another body with jurisdiction over the matter.
6. The facts or questions presented in the petition are unclear, over broad, insufficient, or otherwise inappropriate as a basis upon which to issue an order.
7. There is no need to issue an order because the questions raised in the petition have been settled due to a change in circumstances.
8. The petition is not based upon facts calculated to aid in the planning of future conduct but is, instead, based solely upon prior conduct in an effort to establish the effect of that conduct or to challenge an agency decision already made.
9. The petition requests a declaratory order that would necessarily determine the legal rights, duties, or responsibilities of other persons who have not joined in the petition, intervened separately, or filed a similar petition and whose position on the questions presented may fairly be presumed to be adverse to that of petitioner.
10. The petitioner requests the workers’ compensation commissioner to determine whether a statute is unconstitutional on its face.

5.9(2) Action on refusal. A refusal to issue a declaratory order must indicate the specific grounds for the refusal and constitutes final agency action on the petition.

5.9(3) Filing of new petition. Refusal to issue a declaratory order pursuant to this provision does not preclude the filing of a new petition that seeks to eliminate the grounds for the workers’ compensation commissioner’s refusal to issue an order.

876—5.10(17A) Contents of order—effective date. In addition to the ruling itself, a declaratory order must contain the date of its issuance, the name of petitioner and all intervenors, the specific statutes,
rules, policies, decisions, or orders involved, the particular facts upon which it is based, and the reasons for its conclusion.

A declaratory order is effective on the date of issuance.

876—5.11(17A) Copies of orders. A copy of all orders issued in response to a petition for a declaratory order shall be mailed promptly to the original petitioner and all intervenors.

876—5.12(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 workers’ compensation commissioner, the petitioner, and any intervenors who consent to be bound and is applicable only in circumstances where the relevant facts and the law involved are indistinguishable from those on which the order was based. As to all other persons, a declaratory order serves only as precedent and is not binding on the workers’ compensation commissioner. The issuance of a declaratory order constitutes final agency action on the petition.

876—5.13(17A) Filing fee. No filing fee is due for filing a petition for declaratory order or a petition for intervention. See 876—paragraph 4.8(2) “a.”

These rules are intended to implement Iowa Code section 17A.9.

[Emergency filed and effective 9/19/75—published 10/6/75]
[Filed 11/17/75, Notice 10/6/75—published 12/1/75, effective 1/5/76]
[Filed 9/26/80, Notice 8/20/80—published 10/15/80, effective 11/19/80]
[Filed emergency 7/12/85—published 7/31/85, effective 7/12/85]
[Editorially transferred from [500] to [343] IAC Supp. 9/24/86, see IAB 7/16/86]
[Filed emergency 11/24/86—published 12/17/86, effective 11/24/86]
[Filed 1/23/87, Notice 12/17/86—published 2/11/87, effective 3/18/87]
[Filed 1/10/97, Notice 12/4/96—published 1/29/97, effective 3/5/97]
[Filed emergency 7/1/98—published 7/29/98, effective 7/1/98]
[Filed 5/12/00, Notice 4/5/00—published 5/31/00, effective 7/5/00]
[Filed ARC 3528C (Notice ARC 3414C, IAB 10/25/17), IAB 12/20/17, effective 1/24/18]
[Filed Emergency After Notice ARC 4568C (Notice ARC 4472C, IAB 6/5/19), IAB 7/31/19, effective 7/10/19]
CHAPTER 10
INFORMAL DISPUTE RESOLUTION PROCEDURES
[Prior to 1/29/97 see Industrial Services Division[343]]
[Prior to 7/29/98 see Industrial Services Division[873]Ch 10]

876—10.1(17A,85,86) Informal dispute resolution procedures. The workers’ compensation commissioner or the workers’ compensation commissioner’s designee (hereinafter collectively referred to as the workers’ compensation commissioner) shall be available to resolve disputes relating to the Iowa workers’ compensation law (Iowa Code chapters 85, 85A, 85B, 86, and 87) prior to the initiation of a contested case proceeding. Persons are encouraged to utilize the informal procedure provided herein so that a settlement may be reached between the parties without the necessity of a contested case proceeding. Informal procedures may be initiated as requested by any party either before or after a first report of injury has been filed. After a first report of injury is filed with the workers’ compensation commissioner, a letter is provided to the injured employee. That letter includes an explanation of the function of the office of the workers’ compensation commissioner, an explanation of informal dispute resolution procedures and information contained on the first report of injury. Additionally, even where a first report of injury is not on file, any party who elects to engage in informal dispute resolution may contact the workers’ compensation commissioner by telephone or mail for information regarding the claim. Documentation regarding the claim may be submitted to or requested by the workers’ compensation commissioner. The workers’ compensation commissioner may respond to the parties either by telephone or, when appropriate, in writing regarding the information sought by the parties.

The informal procedures described in these rules are designed to be flexible enough to resolve any issue that any party believes is amenable to informal dispute resolution or that with the consent of the workers’ compensation commissioner should be made the subject of informal dispute resolution procedures.

10.1(1) Nondisputed matters. If the parties agree that the claimant is correctly compensated and all benefits due and owing have been or will be paid, the parties need not file any other pleading or document with the workers’ compensation commissioner except that claims activity reports must be filed in accordance with rule 876—3.1(17A).

10.1(2) Disputed matters. In the event the parties dispute whether the claimant is entitled to compensation or whether the claimant has received all benefits to which the claimant was entitled, then the parties to the dispute may elect to engage in the informal dispute resolution procedures described herein.

10.1(3) Notification of election, statute of limitations. Within the time a claimant may file an original proceeding with the workers’ compensation commissioner, either party to a disputed claim may notify the workers’ compensation commissioner of the desire to engage in an informal proceeding to resolve the dispute. If the dispute cannot be resolved informally, claimant will have the right to file an original notice and petition to commence a contested case proceeding as provided by 876—Chapter 4. An election to engage in informal dispute resolution procedures will not toll the statute of limitations for filing an original notice and petition.

10.1(4) Good faith effort to resolve disputes. Before the parties will be allowed to elect any alternative dispute resolution procedures including those identified in rules 876—4.40(73GA,ch1261) and 876—4.46(17A,85,86), they must make a good faith effort to resolve their dispute. The parties may file a professional statement signed by all parties and their representatives or an affidavit by an unrepresented party filed with the workers’ compensation commissioner attesting to the good faith attempts to settle the dispute prior to utilizing the procedures described in these rules. The professional statement will be deemed sufficient to meet the requirements of this rule. Notwithstanding the foregoing, a claimant who files a contested case proceeding in order to toll the statute of limitations included in Iowa Code chapters 85, 85A, 85B, and 86 may elect alternative dispute resolution procedures including the informal procedures described in this chapter even though claimant or claimant’s representative did not engage in settlement negotiations prior to the time the contested case proceeding was filed.
10.1(5) Informal dispute resolution procedures include the dispute resolution procedures described in rule 876—4.40(73GA,ch1261). The workers’ compensation commissioner has the power to impose sanctions in informal dispute resolution procedures.

10.1(6) Rescinded IAB 6/22/94, effective 7/1/94.

10.1(7) An employee of the division of workers’ compensation who has been involved in informal dispute resolution pursuant to subrules 10.1(5) and 10.1(6) shall not be a witness in any contested case proceeding under 876—Chapter 4.

10.1(8) Nothing in this rule is intended to prevent settlement prior to using the dispute resolution procedures.

This rule is intended to implement Iowa Code section 86.8, and 1990 Iowa Acts, chapter 1261, section 3.


876—10.3(17A,85,86) Health service dispute resolution.

10.3(1) The purpose of this rule and rule 876—4.46(17A,85,86) is to establish the procedures for resolving a dispute under Iowa Code section 85.27 between a provider and a responsible party over the treatment rendered by a provider to an injured worker. Utilization of these procedures by a responsible party is not an admission of liability for any other proceeding. This rule is effective October 7, 1992.

10.3(2) Definitions. The following definitions apply to this rule and rule 876—4.46(17A,85,86).

“Dispute” means a disagreement between a provider and responsible party over the necessity of service or reasonableness of charges or both; a disagreement between a provider and a responsible party over the necessity for or the reasonableness of charges for crutches, artificial members and appliances; and includes only those situations where liability or extent of liability is not an issue.

“Workers’ compensation commissioner” means the workers’ compensation commissioner or the workers’ compensation commissioner’s designee.

“Person” means individual, corporation, government or governmental subdivision or agency, business trust, estate, trust, partnership or association, or any other legal entity.

“Provider” means any person furnishing surgical, medical, dental, osteopathic, chiropractic, podiatric, physical rehabilitation, nursing, ambulance, hospital services and supplies, crutches, artificial members and appliances.

“Responsible party” means the person who is liable for payment of medical services provided pursuant to the Iowa workers’ compensation laws and includes an employer, an employer who has been relieved from insurance pursuant to Iowa Code section 87.11, and an insurance carrier which provides an employer workers’ compensation insurance.

10.3(3) Informal resolution of disputes.

a. The charges not in controversy shall be paid to the provider prior to utilization of the procedures outlined in this rule.

b. A responsible party who refuses to pay the amount in controversy of a dispute shall give the provider written notice of the dispute within 60 days of receiving a bill with proper supporting documentation. The written notice shall specify:

(1) The name of the patient-employee;

(2) The name of the employer on the date of injury;

(3) The date of the treatment in dispute;

(4) The amount charged for the treatment, the amount of the charge the responsible party agrees to pay, and the amount in dispute;

(5) The reason for belief that the bill is excessive or unnecessary and documentation relied upon to formulate the belief;

(6) The address to use in directing correspondence to the responsible party regarding the dispute;

(7) The provider’s right to utilize the procedures specified in this rule and rule 876—4.46 (17A,85,86);

(8) The provisions of 10.3(3)“c,” 10.3(3)“d,” and 876—subrule 4.46(2);
(9) The provider or the responsible party is prohibited by Iowa Code section 85.27 from seeking payment from the injured worker when there is a dispute regarding reasonableness of a fee.

c. If the provider agrees to accept the amount of the charge the responsible party has paid, the provider shall notify the responsible party.

d. If the provider does not agree to accept the amount of the charge the responsible party agrees to pay, the provider shall notify the responsible party in writing. The provider and the responsible party shall submit the dispute to a mutually agreed upon person for review. The person reviewing the dispute under this rule will not be the workers’ compensation commissioner. If the provider and the responsible party cannot agree upon the person to make the review, they shall, within 90 days of time the provider notified the responsible party of the disagreement, each recommend to the workers’ compensation commissioner one person to do the review. The workers’ compensation commissioner may choose the person or persons recommended to make the review. A person other than the persons recommended may be chosen at the discretion of the workers’ compensation commissioner. The selected person or persons shall review information submitted by the provider and the responsible party and make a determination.

e. The person making the review shall make a determination of the amount that is reasonable and necessary. The determination shall be made as soon as practicable and shall be dated. It shall be in writing and specify the facts relied upon. The person making the review may choose any amount to set the reasonableness of a charge. If the person chosen to make the review does not make a determination within a reasonable time, that person may be discharged without being paid.

f. Costs. The costs of the person making the review shall be paid as mutually agreed by the provider and the responsible party. In the event of no agreement the costs shall be paid by whomever chose an amount further from the determination of the person reviewing the matter. If the amount is equally close to both parties, the costs shall be shared equally. However, if the workers’ compensation commissioner selects the person or persons to do the review, the costs shall be shared equally.

g. Nothing in this rule is intended to prevent providers and responsible parties from developing other procedures to informally resolve their disputes.

10.3(4) See rule 876—4.46(17A,85,86) for contested case procedures.

10.3(5) WCES shall not be used for health service dispute matters.

This rule is intended to implement Iowa Code sections 17A.10, 17A.12, 85.27 and 86.8.

[ARC 4568C; IAB 7/31/19, effective 7/10/19]

[Filed 2/15/91, Notice 12/26/90—published 3/6/91, effective 4/10/91]
[Filed 8/13/92, Notice 7/8/92—published 9/2/92, effective 10/7/92]
[Filed emergency 6/3/94—published 6/22/94, effective 7/1/94]
[Filed 8/26/94, Notice 7/20/94—published 9/14/94, effective 10/19/94]
[Filed 1/10/97, Notice 12/4/96—published 1/29/97, effective 3/5/97]
[Filed emergency 7/1/98—published 7/29/98, effective 7/1/98]

[Filed Emergency After Notice ARC 4568C (Notice ARC 4472C, IAB 6/5/19), IAB 7/31/19, effective 7/10/19]
CHAPTER 11
ELECTRONIC DATA INTERCHANGE (EDI)

876—11.1(85,86) Purpose. The purpose of this chapter is to establish the procedure for fulfilling reporting requirements of the division of workers’ compensation.

876—11.2(85,86) Definitions. The following definitions apply to 876—Chapter 3 and this chapter.

“EDI” or “electronic data interchange” means electronic transmission or reception, or both, of data through a telecommunications process utilizing a value-added network or the Internet as set forth in the EDI partnering agreement.

“EDI partnering agreement” means the written agreement between an entity and the division of workers’ compensation specifying the terms and manner of reporting by EDI.

“Filed” means receipt and acceptance of a report by the division of workers’ compensation. A report is considered to be “filed” on the date it is accepted (TA) by the division of workers’ compensation. A report that is submitted but rejected (TR) is not considered “filed.”

“Report” means a first report of injury (FROI) or a subsequent report of injury (SROI), or both.

“Reporter” means the person who is responsible for reporting to the division of workers’ compensation pursuant to the Iowa workers’ compensation laws and includes an employer, an employer who has been relieved from insurance pursuant to Iowa Code section 87.11, and an insurance carrier which provides an employer workers’ compensation insurance.

“Reporting” means submission of claims data and data fields of information of a report.

[ARC 4568C, IAB 7/31/19, effective 7/10/19]

876—11.3(85,86) Form of reporting. The format of EDI reporting must be the current version of the International Association of Industrial Accident Boards and Commissions (IAIABC) Release 3.1 FROI/SROI.

[ARC 4568C, IAB 7/31/19, effective 7/10/19]

876—11.4(85,86) Manner of reporting. The manner of EDI reporting is electronic.

876—11.5(85,86) Voluntary reporting deadline. Rescinded ARC 4568C, IAB 7/31/19, effective 7/10/19.

876—11.6(85,86) Mandatory reporting deadline. All reporters must sign a partnering agreement and begin reporting by EDI Release 3.1 no later than July 16, 2019, or when WCES is available to the public, whichever is later. Reporting by any means other than EDI Release 3.1 after July 16, 2019, will not be acceptable, unless WCES is not available to the public. Reporters are responsible for reporting by EDI. A reporter may contract with another entity for reporting, but the reporter is ultimately responsible for reporting. Any entity reporting on behalf of a reporter must also sign an EDI partnering agreement.

[ARC 4568C, IAB 7/31/19, effective 7/10/19]

876—11.7(85,86) Required reports.

11.7(1) A reporter shall file reports as required by Iowa Code sections 86.11, 86.12, and 86.13, 876—subrules 3.1(1) and 3.1(2), this chapter and the partnering agreement. Reports required to be filed include, but are not limited to, the following:

a. First report of injury (FROI). See 876—subrule 3.1(1);

b. Subsequent report of injury (SROI). See 876—subrule 3.1(2);

c. Annual report on every claim that is open on June 30 each year. The annual report shall show all benefits paid since the claim was initiated through June 30 of the current year. A final report shall be filed in lieu of the annual report if the claim is closed and the final report is filed before the date when the annual report is scheduled to be filed; and

d. Final report filed at the time the claim is closed. The final report indicates that no further benefit payments are contemplated.
11.7(2) A reporter shall file a change to FROI and SROI reports whenever a reporter is made aware that information previously submitted is incorrect. The reporter shall file a change within 45 days after being made aware that previously submitted information is incorrect. Information for which a change shall be filed includes, but is not limited to, the injured employee’s social security number, date of injury, employer’s name, and injured employee’s name. A reporter shall also correct information used in calculation of the compensation rate including, but not limited to, marital status and number of exemptions, average weekly wage, and compensation rate at the time of the employee’s injury. If a final decision by the division of workers’ compensation or a court of law changes any of the previously submitted information, the attorney for the employer and insurance carrier shall notify the reporter. The reporter shall file a change within 45 days of the final decision.

[ARC 4568C, IAB 7/31/19, effective 7/10/19]

These rules are intended to implement Iowa Code sections 85.26, 86.8, 86.11, 86.12 and 86.13.

[Filed 2/15/02, Notice 1/9/02—published 3/6/02, effective 4/10/02]
[Filed 5/20/04, Notice 4/14/04—published 6/9/04, effective 7/14/04]
[Filed 11/4/05, Notice 9/14/05—published 11/23/05, effective 1/1/06]
[Filed Emergency After Notice ARC 4568C (Notice ARC 4472C, IAB 6/5/19), IAB 7/31/19, effective 7/10/19]