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

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

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

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

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

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

Education Department[281]

Replace Analysis
Replace Chapter 15
Replace Chapter 56
Replace Chapter 62

Human Services Department[441]

Replace Chapters 78 and 79
Replace Chapter 83

Homeland Security and Emergency Management Department[605]

Replace Chapter 10

Public Health Department[641]

Replace Analysis
Replace Chapter 7
Replace Chapter 26
Replace Chapter 43
Replace Chapter 73
Replace Chapter 77
Replace Chapter 127

Professional Licensure Division[645]

Replace Chapters 31 and 32

Pharmacy Board[657]

Replace Analysis
Replace Chapter 30

Revenue Department[701]

Replace Analysis
Replace Chapter 42

Transportation Department[761]

Replace Chapter 162
Replace Chapter 821

EDUCATION DEPARTMENT[281]

Created by 1986 Iowa Acts, chapter 1245, section 1401.
Prior to 9/7/88, see Public Instruction Department[670]
(Replacement pages for 9/7/88 published in 9/21/88 IAC)

TITLE I
GENERAL INFORMATION—
DEPARTMENT OPERATIONS

CHAPTER 1
ORGANIZATION AND OPERATION

CHAPTER 2
AGENCY PROCEDURE FOR RULE MAKING AND PETITIONS FOR RULE MAKING
(Uniform Rules)

CHAPTER 3
DECLARATORY ORDERS
(Uniform Rules)

CHAPTER 4
WAIVERS OR VARIANCES FROM ADMINISTRATIVE RULES

CHAPTER 5
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES
(Uniform Rules)

CHAPTER 6
APPEAL PROCEDURES

CHAPTER 12
GENERAL ACCREDITATION STANDARDS

DIVISION I
GENERAL STANDARDS

12.1(256) General standards

DIVISION II
DEFINITIONS

12.2(256) Definitions

DIVISION III
ADMINISTRATION

12.3(256) Administration

DIVISION IV
SCHOOL PERSONNEL

12.4(256) School personnel

DIVISION V
EDUCATION PROGRAM

12.5(256) Education program

DIVISION VI
ACTIVITY PROGRAM

12.6(256) Activity program

DIVISION VII
STAFF DEVELOPMENT

12.7(256,284,284A) Professional development

DIVISION VIII
ACCOUNTABILITY

12.8(256) Accountability for student achievement

DIVISION IX
EXEMPTION REQUEST PROCESS

12.9(256) General accreditation standards exemption request

DIVISION X
INDEPENDENT ACCREDITING AGENCIES

12.10(256) Independent accrediting agencies

CHAPTER 13
Reserved

CHAPTER 14
SCHOOL HEALTH SERVICES

14.1 and 14.2 Reserved
14.3(256) School district and accredited nonpublic school stock epinephrine auto-injector voluntary supply
14.4(256,280) Severability

CHAPTER 15
USE OF ONLINE LEARNING AND TELECOMMUNICATIONS FOR INSTRUCTION BY SCHOOLS

15.1(256) Purpose
15.2(256) Definitions

DIVISION I
USE OF TELECOMMUNICATIONS FOR INSTRUCTION BY SCHOOLS

15.3(256) Interactivity
15.4(256) Course eligibility

CHAPTER 18
SCHOOL FEES

CHAPTERS 19 and 20
Reserved

TITLE III
COMMUNITY COLLEGES

CHAPTER 21
COMMUNITY COLLEGES

DIVISION I
APPROVAL STANDARDS

DIVISION II
COMMUNITY COLLEGE ENERGY APPROPRIATIONS

DIVISION III
INSTRUCTIONAL COURSE FOR DRINKING DRIVERS

DIVISION IV
JOBS NOW CAPITALS ACCOUNT

DIVISION V
STATE COMMUNITY COLLEGE FUNDING PLAN

DIVISION VI
INTERCOLLEGIATE ATHLETIC COMPETITION

DIVISION VII
QUALITY INSTRUCTIONAL CENTER INITIATIVE

DIVISION VIII
PROGRAM AND ADMINISTRATIVE SHARING INITIATIVE

DIVISION IX
APPRENTICESHIP PROGRAM

DIVISION X
MISCELLANEOUS PROVISIONS

CHAPTER 22
SENIOR YEAR PLUS PROGRAM

DIVISION I
GENERAL PROVISIONS

DIVISION II
DEFINITIONS

DIVISION III
ADVANCED PLACEMENT PROGRAM

DIVISION IV
CONCURRENT ENROLLMENT PROGRAM

DIVISION V
POSTSECONDARY ENROLLMENT OPTIONS PROGRAM

DIVISION VI
CAREER ACADEMIES

DIVISION VII
REGIONAL ACADEMIES

DIVISION VIII
INTERNET-BASED AND ICN COURSEWORK

DIVISION IX
PROJECT LEAD THE WAY

CHAPTER 23
ADULT EDUCATION AND LITERACY PROGRAMS

CHAPTER 24
COMMUNITY COLLEGE ACCREDITATION

CHAPTER 25
PATHWAYS FOR ACADEMIC CAREER AND EMPLOYMENT PROGRAM; GAP TUITION ASSISTANCE PROGRAM

DIVISION I
GENERAL PROVISIONS

DIVISION II
PATHWAYS FOR ACADEMIC CAREER AND EMPLOYMENT (PACE) PROGRAM

DIVISION III
GAP TUITION ASSISTANCE PROGRAM

CHAPTER 33
EDUCATING THE HOMELESS

CHAPTER 34
FUNDING FOR CHILDREN RESIDING IN STATE INSTITUTIONS
OR MENTAL HEALTH INSTITUTES

CHAPTER 35
Reserved

TITLE VI
INTERSCHOLASTIC COMPETITION

CHAPTER 36
EXTRACURRICULAR INTERSCHOLASTIC COMPETITION

41.122(256B,34CFR300) Evaluation
41.123(256B,34CFR300) Confidentiality of personally identifiable information
41.124(256B,34CFR300) Transition of children from the Part C program to preschool programs
41.125 to 41.128 Reserved
41.129(256B,34CFR300) Responsibility regarding children in private schools
41.130(256,256B,34CFR300) Definition of parentally placed private school children with disabilities
41.131(256,256B,34CFR300) Child find for parentally placed private school children with disabilities
41.132(256,256B,34CFR300) Provision of services for parentally placed private school children with disabilities: basic requirement
41.133(256,256B,34CFR300) Expenditures
41.134(256,256B,34CFR300) Consultation
41.135(256,256B,34CFR300) Written affirmation
41.136(256,256B,34CFR300) Compliance
41.137(256,256B,34CFR300) Equitable services determined
41.138(256,256B,34CFR300) Equitable services provided
41.139(256,256B,34CFR300) Location of services and transportation
41.140(256,256B,34CFR300) Due process complaints and state complaints
41.141(256,256B,34CFR300) Requirement that funds not benefit a private school
41.142(256,256B,34CFR300) Use of personnel
41.143(256,256B,34CFR300) Separate classes prohibited
41.144(256,256B,34CFR300) Property, equipment, and supplies
41.145(256B,34CFR300) Applicability of rules 281—41.146(256B,34CFR300) to 281—41.147(256B,34CFR300)
41.146(256B,34CFR300) Responsibility of department
41.147(256B,34CFR300) Implementation by department
41.148(256B,34CFR300) Placement of children by parents when FAPE is at issue
41.149(256B,34CFR300) SEA responsibility for general supervision
41.150 Reserved
41.151(256B,34CFR300) Adoption of state complaint procedures
41.152(256B,34CFR300) Minimum state complaint procedures
41.153(256B,34CFR300) Filing a complaint
41.154(256B,34CFR300) Methods of ensuring services
41.155(256B,34CFR300) Hearings relating to AEA or LEA eligibility
41.156(256B,34CFR300) Personnel qualifications
41.157 to 41.161 Reserved
41.162(256B,34CFR300) Supplementation of state, local, and other federal funds
41.163(256B,34CFR300) Maintenance of state financial support
41.164 Reserved
41.165(256B,34CFR300) Public participation
41.166(256B,34CFR300) Rule of construction
41.167(256B,34CFR300) State advisory panel
41.168(256B,34CFR300) Advisory panel membership
41.169(256B,34CFR300) Advisory panel duties
41.170(256B,34CFR300) Suspension and expulsion rates
41.171 Reserved
41.172(256B,34CFR300) Access to instructional materials
41.173(256B,34CFR300) Overidentification and disproportionality
41.174(256B,34CFR300) Prohibition on mandatory medication
41.175 Reserved
41.176(256B) Special school provisions
41.177(256B) Facilities
41.178(256B) Materials, equipment and assistive technology

DIVISION VI
ADDITIONAL RULES RELATED TO AEAs, LEAs, AND SPECIAL EDUCATION

DIVISION VII
PROCEDURAL SAFEGUARDS

DIVISION X
PRESCHOOL GRANTS FOR CHILDREN WITH DISABILITIES

DIVISION XI
ADDITIONAL RULES CONCERNING FINANCE AND PUBLIC ACCOUNTABILITY

DIVISION XII
PRACTICE BEFORE MEDIATORS AND ADMINISTRATIVE LAW JUDGES

DIVISION XIII
ADDITIONAL RULES NECESSARY TO IMPLEMENT AND APPLY THIS CHAPTER

CHAPTER 42
Reserved

TITLE VIII
SCHOOL TRANSPORTATION

CHAPTER 43
PUPIL TRANSPORTATION

DIVISION I
TRANSPORTATION ROUTES

DIVISION II
PRIVATE CONTRACTORS

DIVISION III
FINANCIAL RECORDS AND REPORTS

DIVISION IV
USE OF SCHOOL BUSES

DIVISION V
THE BUS DRIVER

DIVISION VI
PURCHASE OF BUSES

DIVISION VII
MISCELLANEOUS REQUIREMENTS

DIVISION VIII
COMMON CARRIERS

CHAPTER 44
SCHOOL BUSES

CHAPTER 45
Reserved

TITLE IX
VOCATIONAL EDUCATION

CHAPTER 46
VOCATIONAL EDUCATION PROGRAMS

CHAPTER 47
CAREER ACADEMIES

CHAPTER 48
STATEWIDE WORK-BASED LEARNING INTERMEDIARY NETWORK

CHAPTER 49
INDIVIDUAL CAREER AND ACADEMIC PLAN

CHAPTER 50
Reserved

TITLE X
VETERANS' TRAINING

CHAPTER 51
APPROVAL OF ON-THE-JOB TRAINING ESTABLISHMENTS
UNDER THE MONTGOMERY G.I. BILL

CHAPTER 52
APPROVAL OF EDUCATIONAL INSTITUTIONS
FOR THE EDUCATION AND TRAINING OF ELIGIBLE VETERANS
UNDER THE MONTGOMERY G.I. BILL

CHAPTERS 53 to 55
Reserved

TITLE XI
VOCATIONAL REHABILITATION EDUCATION

CHAPTER 56
IOWA VOCATIONAL REHABILITATION SERVICES

DIVISION IX
STATE REHABILITATION COUNCIL

DIVISION X
IOWA SELF-EMPLOYMENT PROGRAM
(A/K/A ENTREPRENEURS WITH DISABILITIES PROGRAM)

CHAPTER 57
Reserved

TITLE XII
PROGRAMS ADMINISTRATION

CHAPTER 58
SCHOOL BREAKFAST AND LUNCH PROGRAM; NUTRITIONAL CONTENT STANDARDS FOR OTHER FOODS AND BEVERAGES

DIVISION I
SCHOOL BREAKFAST AND LUNCH PROGRAM

DIVISION II
NUTRITIONAL CONTENT STANDARDS FOR OTHER FOODS AND BEVERAGES

CHAPTER 59
GIFTED AND TALENTED PROGRAMS

CHAPTER 60
PROGRAMS FOR STUDENTS OF LIMITED ENGLISH PROFICIENCY

CHAPTER 64
CHILD DEVELOPMENT COORDINATING COUNCIL

CHAPTER 65
INNOVATIVE PROGRAMS FOR AT-RISK EARLY ELEMENTARY STUDENTS

DIVISION III
INNOVATION ZONE SCHOOLS

CHAPTER 69
Reserved

TITLE XIII
AREA EDUCATION AGENCIES

CHAPTERS 70 and 71
Reserved

CHAPTER 72
ACCREDITATION OF AREA EDUCATION AGENCIES

TITLE XIV
TEACHERS AND PROFESSIONAL LICENSING

CHAPTERS 73 to 76
Reserved

CHAPTER 77
STANDARDS FOR TEACHER INTERN PREPARATION PROGRAMS

TEACHER INTERN PREPARATION PROGRAM STANDARDS

CHAPTER 78
Reserved

CHAPTER 79
STANDARDS FOR PRACTITIONER AND ADMINISTRATOR PREPARATION PROGRAMS

DIVISION I
GENERAL STANDARDS APPLICABLE TO ALL PRACTITIONER PREPARATION PROGRAMS

DIVISION II
SPECIFIC EDUCATION STANDARDS APPLICABLE TO ALL PRACTITIONER PREPARATION PROGRAMS

DIVISION III
SPECIFIC EDUCATION STANDARDS APPLICABLE ONLY TO INITIAL PRACTITIONER PREPARATION PROGRAMS FOR TEACHER CANDIDATES

DIVISION IV
SPECIFIC EDUCATION STANDARDS APPLICABLE ONLY TO ADMINISTRATOR PREPARATION PROGRAMS

DIVISION V
SPECIFIC EDUCATION STANDARDS APPLICABLE ONLY TO PRACTITIONER PREPARATION PROGRAMS OTHER THAN TEACHER OR ADMINISTRATOR PREPARATION PROGRAMS

CHAPTER 80
STANDARDS FOR PARAEDUCATOR PREPARATION PROGRAMS

CHAPTER 81
STANDARDS FOR SCHOOL BUSINESS OFFICIAL PREPARATION PROGRAMS

CHAPTER 82
STANDARDS FOR SCHOOL ADMINISTRATION MANAGER PROGRAMS

CHAPTER 83
TEACHER AND ADMINISTRATOR QUALITY PROGRAMS

DIVISION I
GENERAL STANDARDS APPLICABLE TO BOTH ADMINISTRATOR AND TEACHER QUALITY PROGRAMS

DIVISION II
SPECIFIC STANDARDS APPLICABLE TO TEACHER QUALITY PROGRAMS

DIVISION III
SPECIFIC STANDARDS APPLICABLE TO ADMINISTRATOR QUALITY PROGRAMS

CHAPTER 84
FINANCIAL INCENTIVES FOR NATIONAL BOARD CERTIFICATION

CHAPTERS 85 to 93
Reserved

TITLE XV
EDUCATIONAL EXCELLENCE

CHAPTER 94
ADMINISTRATIVE ADVANCEMENT AND RECRUITMENT PROGRAM

CHAPTER 95
EQUAL EMPLOYMENT OPPORTUNITY
AND AFFIRMATIVE ACTION IN EDUCATIONAL AGENCIES

TITLE XVI
SCHOOL FACILITIES

CHAPTER 96
STATEWIDE/LOCAL OPTION SALES AND
SERVICES TAX FOR SCHOOL INFRASTRUCTURE

CHAPTER 97
SUPPLEMENTARY WEIGHTING

CHAPTER 98
FINANCIAL MANAGEMENT OF CATEGORICAL FUNDING

DIVISION I
GENERAL PROVISIONS

DIVISION II
APPROPRIATE USE OF BUDGETARY ALLOCATIONS

DIVISION III
APPROPRIATE USE OF GRANTS IN AID

DIVISION IV
APPROPRIATE USE OF SPECIAL TAX LEVIES AND FUNDS

98.60(24,29C,76,143,256,257,274,275,276,279,280,282,283A,285,291,296,298,298A,300,301,423E,423F,565,670) Levies and funds
98.61(24,143,257,275,279,280,285,297,298,298A,301,473,670) General fund
98.62(279,296,298,670) Management fund
98.63(298) Library levy fund
98.64(279,283,297,298) Physical plant and equipment levy (PPEL) fund
98.65(276,300) Public educational and recreational levy (PERL) fund
98.66(257,279,298A,565) District support trust fund
98.67(257,279,298A,565) Permanent funds
98.68(76,274,296,298,298A) Debt service fund
98.69(76,273,298,298A,423E,423F) Capital projects fund
98.70(279,280,298A) Student activity fund
98.71(298A) Entrepreneurial education fund
98.72(256B,257,298A) Special education instruction fund
98.73(282,298A) Juvenile home program instruction fund
98.74(283A,298A) School nutrition fund
98.75(279,298A) Child care and before- and after-school programs fund
98.76(298A) Regular education preschool fund
98.77(298A) Student construction fund
98.78(298A) Other enterprise funds
98.79 to 98.81 Reserved
98.82(298A) Internal service funds
98.83 to 98.91 Reserved
98.92(257,279,298A,565) Private purpose trust funds
98.93(298A) Other trust funds
98.94 to 98.100 Reserved
98.101(298A) Agency funds
98.102 to 98.110 Reserved
98.111(24,29C,257,298A) Emergency levy fund
98.112(275) Equalization levy fund

CHAPTER 99
BUSINESS PROCEDURES AND DEADLINES

99.1(257) Definitions
99.2(256,257,285,291) Submission deadlines
99.3(257) Good cause for late submission
99.4(24,256,257,291) Budgets, accounting and reporting

CHAPTER 100
Reserved

TITLE XVII
PROTECTION OF CHILDREN

CHAPTER 101
Reserved

CHAPTER 102
PROCEDURES FOR CHARGING AND INVESTIGATING INCIDENTS OF ABUSE OF STUDENTS BY SCHOOL EMPLOYEES

CHAPTER 103
CORPORAL PUNISHMENT BAN; RESTRAINT; PHYSICAL CONFINEMENT AND DETENTION

CHAPTERS 104 to 119
Reserved

TITLE XVIII
EARLY CHILDHOOD

CHAPTER 120
EARLY ACCESS INTEGRATED SYSTEM OF EARLY INTERVENTION SERVICES

DIVISION I
PURPOSE AND APPLICABILITY

DIVISION II
DEFINITIONS

DIVISION III
STATE ELIGIBILITY FOR A GRANT AND REQUIREMENTS
FOR A STATEWIDE SYSTEM: GENERAL AUTHORITY AND ELIGIBILITY

120.343(34CFR303)	IFSP team meeting and periodic review
120.344(34CFR303)	Content of an IFSP
120.345(34CFR303)	Interim IFSPs—provision of services before evaluations and assessments are completed
120.346(34CFR303)	Responsibility and accountability
120.347 to 120.399	Reserved

DIVISION VI
PROCEDURAL SAFEGUARDS

120.400(34CFR303)	General responsibility of lead agency for procedural safeguards
120.401(34CFR303)	Confidentiality and opportunity to examine records
120.402(34CFR303)	Confidentiality
120.403(34CFR303)	Definitions
120.404(34CFR303)	Notice to parents
120.405(34CFR303)	Access rights
120.406(34CFR303)	Record of access
120.407(34CFR303)	Records on more than one child
120.408(34CFR303)	List of types and locations of information
120.409(34CFR303)	Fees for records
120.410(34CFR303)	Amendment of records at a parent's request
120.411(34CFR303)	Opportunity for a hearing
120.412(34CFR303)	Result of hearing
120.413(34CFR303)	Hearing procedures
120.414(34CFR303)	Consent prior to disclosure or use
120.415(34CFR303)	Safeguards
120.416(34CFR303)	Destruction of information
120.417(34CFR303)	Enforcement
120.418 and 120.419	Reserved
120.420(34CFR303)	Parental consent and ability to decline services
120.421(34CFR303)	Prior written notice and procedural safeguards notice
120.422(34CFR303)	Surrogate parents
120.423 to 120.429	Reserved
120.430(34CFR303)	State dispute resolution options
120.431(34CFR303)	Mediation
120.432(34CFR303)	Adoption of state complaint procedures
120.433(34CFR303)	Minimum state complaint procedures
120.434(34CFR303)	Filing a complaint
120.435(34CFR303)	Appointment of an administrative law judge
120.436(34CFR303)	Parental rights in due process hearing proceedings
120.437(34CFR303)	Convenience of hearings and timelines
120.438(34CFR303)	Civil action
120.439(34CFR303)	Limitation of actions
120.440(34CFR303)	Rule of construction
120.441(34CFR303)	Attorney fees
120.442 to 120.448	Reserved
120.449(34CFR303)	State enforcement mechanisms
120.450 to 120.499	Reserved

DIVISION VII
USE OF FUNDS; PAYOR OF LAST RESORT

120.500(34CFR303)	Use of funds, payor of last resort, and system of payments
120.501(34CFR303)	Permissive use of funds by the department
120.502 to 120.509	Reserved
120.510(34CFR303)	Payor of last resort

CHAPTER 15
USE OF ONLINE LEARNING AND TELECOMMUNICATIONS FOR INSTRUCTION BY SCHOOLS

281—15.1(256) Purpose. It is the purpose of this chapter to give guidance and direction for the use of online learning or the use of telecommunications as an instructional tool for students enrolled in kindergarten through grade 12. It is a further purpose of this chapter to provide guidance for students and school districts regarding enrollment of students in one or more courses offered by Iowa Learning Online.
[**ARC 0522C**, IAB 12/12/12, effective 1/16/13]

281—15.2(256) Definitions.

"Appropriately licensed and endorsed" means possession of current and valid licensure by the Iowa board of educational examiners to practice at a prescribed educational level in a specified content area.

"Class size" refers to the total group taught during a time period by a teacher or teaching team with students at one or more sites.

"Delivered primarily over the Internet" means more than 50 percent of the course content or instruction or both is delivered using the global computer network of the World Wide Web or Internet.

"Department" means the department of education.

"Exclusive instruction" means without the use of any other form of instructional delivery.

"Iowa Learning Online" or *"ILO"* means the department's digital learning initiative to provide online courses to students enrolled or dually enrolled in participating school districts and accredited nonpublic schools. ILO is more specifically explained in Division III herein.

"Online learning" or *"online coursework"* means educational instruction and content delivered primarily over the Internet. "Online learning" or "online coursework" does not include print-based correspondence curricula, broadcast television or radio, videocassettes, or stand-alone educational software programs that lack a significant Internet-based instructional component.

"Participating school district or accredited nonpublic school" means a school district or accredited nonpublic school that has registered a student in an ILO course and has agreed to provide the student with access, during the school day, to a computer that has Internet connectivity through a direct connection as well as access to a telephone or an ICN classroom and transportation to periodic laboratory components, if needed or required. The district has also agreed to provide a staff member to serve as a site coordinator and contact for the ILO teacher, to monitor progress, and to serve as the student's advocate by providing academic coaching and technical support. Further, the district has agreed to award a grade and credit on the student's district-level transcript, based on the end-of-course evaluation by the ILO teacher.

"Telecommunications" means narrowcast communications through systems that are directed toward a narrowly defined audience and includes interactive live communications. "Telecommunications" does not include online learning.
[**ARC 0522C**, IAB 12/12/12, effective 1/16/13]

DIVISION I
USE OF TELECOMMUNICATIONS FOR INSTRUCTION BY SCHOOLS

281—15.3(256) Interactivity. Courses delivered primarily via telecommunications shall employ live interactive systems which allow, at a minimum, one-way video and two-way audio communication. An annual waiver may be granted by the department for a telecommunications system that does not include audio but has alternative contemporaneous, interactive communication ability and is consistent with sound instructional practice.
[**ARC 0522C**, IAB 12/12/12, effective 1/16/13]

281—15.4(256) Course eligibility. Telecommunications may be employed as a means to deliver any course, including a course required for accreditation by the department, provided it is not the exclusive means of instructional delivery.
[**ARC 0522C**, IAB 12/12/12, effective 1/16/13]

281—15.5(256) Teacher preparation and accessibility. A teacher appropriately licensed and endorsed for the educational level and content area being taught shall be present and responsible for the instructional program at the receiving site if a presenter of material transmitted via telecommunications is not an appropriately licensed and endorsed teacher for the educational level and content area. If a presenter of material transmitted via telecommunications is an appropriately licensed and endorsed teacher for the educational level and content area, a supervising teacher, or aide to whom a supervising teacher is readily available for consultation, shall supervise and monitor the curriculum and students and be readily accessible to the students. Prior to being assigned initially to deliver instruction via telecommunications, a teacher shall receive training regarding effective practices which enhance learning by telecommunications.
[**ARC 0522C**, IAB 12/12/12, effective 1/16/13]

281—15.6(256) School responsibilities. Each board of a school district or an accredited nonpublic school employing telecommunications for instruction shall develop policies relative to the use of telecommunications in the delivery of the educational program that are consistent with effective clinical practice. The school district or accredited nonpublic school shall report its use of telecommunications for instruction annually to the department on forms provided by the department. This report shall include:

1. To whom the instruction was delivered including class size, type of class (such as seminar or lecture), and grade level;
2. The course description and schedule of instruction;
3. The number, assignment, licensure including the licensing folder number, and the training received regarding effective practices which enhance learning by telecommunications of all staff involved in the teaching/learning process at both the origination and the receiving sites; and
4. The type of telecommunications used for course delivery, e.g., Internet, ICN, Polycom, etc.

[**ARC 0522C**, IAB 12/12/12, effective 1/16/13]

DIVISION II
ONLINE LEARNING OFFERED BY A SCHOOL DISTRICT

281—15.7(256) School district responsibilities. Subject to the prohibition in rule 281—15.8(256), any online coursework offered by a school district shall be offered solely to resident students of the school district, or students attending the school district through a sharing agreement with another school district, and shall be taught by a teacher appropriately licensed and endorsed for the educational level and content area being taught. The teacher may be employed directly by the school district or by a third-party provider of the online curricula used by the school district. Teachers employed by the school district shall be subject to the provisions of Iowa Code chapters 272, 279, and 284. Teachers employed by a third-party provider shall be subject to the provisions of Iowa Code chapter 272; these teachers must be given access to appropriate professional development by the school district, but otherwise are not subject to the provisions of Iowa Code chapters 279 and 284.
[**ARC 0522C**, IAB 12/12/12, effective 1/16/13]

281—15.8(256) Prohibition regarding open enrollment. Open enrollment of students to a school district that offers online coursework is limited to open enrollment to the receiving school districts of Cumberland-Anita-Massena (CAM) and Clayton Ridge, pursuant to Iowa Code section 256.7(32)*"c"* as amended by 2015 Iowa Acts, Senate File 510, section 99. In implementing any numerical limitation required by Iowa Code section 256.7(32)*"c"* as amended by 2015 Iowa Acts, Senate File 510, section 99, priority shall be given to students who are documented victims of bullying and harassment, as defined in Iowa Code section 280.28.
[**ARC 0522C**, IAB 12/12/12, effective 1/16/13; **ARC 2313C**, IAB 12/9/15, effective 1/13/16]

281—15.9(256) Special education services. Children with disabilities may not be categorically excluded from admission to online learning programs or from enrollment in online coursework.

15.9(1) Whether an online course or online learning is appropriate to a child with a disability must be determined by the child's needs, not by the child's weightedness. If a child's individualized education program (IEP) goals cannot be met in online learning, with or without supplementary aids and services or modifications, online learning is not appropriate to the child.

15.9(2) If a child's IEP team determines that online learning is inappropriate to the child, the child's parents are entitled to prior written notice pursuant to rule 281—41.503(256B,34CFR300) and to have available to them the procedural safeguards provided under rule 281—41.504(256B,34CFR300).

15.9(3) When a child with an IEP seeks enrollment into an online learning program by means of open enrollment, the child's IEP team shall determine that the child meets the open enrollment requirements under 281—Chapter 17. In addition, the child's IEP team, together with representatives of the resident and receiving districts and the relevant area education agencies, shall determine whether the receiving district is able to provide an appropriate online education to the child, either with or without supplementary aids and services or modifications. Any dispute about whether the receiving district's program is appropriate shall be resolved by the director of special education of the area education agency in which the receiving district is located. The child shall remain in the child's resident district while any dispute about the appropriateness of the receiving district's program is pending.
[**ARC 0522C**, IAB 12/12/12, effective 1/16/13]

DIVISION III
IOWA LEARNING ONLINE (ILO)

281—15.10(256) Appropriate applications of ILO coursework. ILO courses are intended to help Iowa school districts expand learning opportunities by providing opportunities for individual students to take one or more courses offered "at a distance" using technologies such as the Internet and interactive videoconferencing. Participating school districts and accredited nonpublic schools may also enroll students in ILO courses if online learning is more suited to a specific student's circumstances.
[**ARC 0522C**, IAB 12/12/12, effective 1/16/13]

281—15.11(256) Inappropriate applications of ILO coursework; criteria for waivers.

15.11(1) *General.* ILO courses are not to be used by a participating school district or accredited nonpublic school as a long-term substitute for any course required to be offered and taught under 281—Chapter 12.

15.11(2) *Waiver of subrule 15.11(1): ILO coursework.* The department may grant for one year a waiver from the requirement to offer and teach a specific subject if the school district or accredited nonpublic school documents all of the following:

a. The subject and grading period or periods for which waiver is requested.

b. Reasons why the school district or accredited nonpublic school does not have a teacher employed who is appropriately licensed and endorsed for the educational level and content area being taught.

c. The steps taken by the school district or accredited nonpublic school to employ a teacher who is appropriately licensed and endorsed for the educational level and content area being taught.

d. Approval of the request by the local school board.

15.11(3) *Additional waiver of subrule 15.11(1): Coursework not available through ILO.* In addition to the requirements of rule 281—15.7(256), the specified subject may alternatively be provided by the school district or school if all of the following requirements are met:

a. The course content is provided through an online learning platform by an Iowa licensed teacher with online learning experience.

b. The course content provided is aligned with school district or school standards and satisfies the requirements of rule 281—15.13(256).

c. The course is not offered by ILO pursuant to this chapter, or the course offered by ILO lacks the capacity to accommodate additional students.

d. The course is the sole course per semester that the school district or school is providing instead of ILO pursuant to this rule.
[**ARC 0522C**, IAB 12/12/12, effective 1/16/13; **ARC 2861C**, IAB 12/7/16, effective 1/11/17]

281—15.12(256) School and school district responsibilities. Each participating school district and accredited nonpublic school shall submit its online curricula, excluding coursework provided by ILO, to the department for review. Each participating school district and accredited nonpublic school shall include in its comprehensive school improvement plan submitted pursuant to Iowa Code section 256.7, subsection 21, a list and description of the online coursework offered by the school or school district, excluding coursework provided by ILO. Each participating school district and accredited nonpublic school is responsible for recording grades received for ILO coursework in a student's permanent record and for awarding graduation credit for ILO coursework. Each participating school district and accredited nonpublic school shall identify a site coordinator to serve as a student advocate and as a liaison between the initiative staff and teachers and the school district or accredited nonpublic school.
[**ARC 0522C**, IAB 12/12/12, effective 1/16/13]

281—15.13(256) Department responsibilities. The department shall annually evaluate the quality of courses offered under ILO to ensure that coursework is rigorous and of high quality and is aligned with Iowa's core curriculum and core content requirements and standards as well as with national standards of quality for online courses issued by an internationally recognized association for elementary and secondary online learning. The department shall ensure that all ILO coursework is taught by a teacher who is appropriately licensed and endorsed for the educational level and content area being taught and who has completed an online-learning-for-Iowa-educators professional development course offered by an area education agency, a teacher preservice program, or comparable coursework.
[**ARC 0522C**, IAB 12/12/12, effective 1/16/13]

281—15.14(256) Enrollment in an ILO course. A student must be enrolled in a participating school district or accredited nonpublic school. The student's school of enrollment registers the student for the desired ILO course. Students may not enroll or be enrolled by their parents or guardians in ILO courses directly. Students under competent private instruction may access ILO coursework on the same basis as regularly enrolled students of the school district by dual enrollment in the school district in which the student is a resident.
[**ARC 0522C**, IAB 12/12/12, effective 1/16/13]

These rules are intended to implement Iowa Code sections 256.2, 256.7, 256.9, and 256.42.

[Filed 4/13/90, Notice 1/10/90—published 5/2/90, effective 6/6/90]
[Filed ARC 0522C (Notice ARC 0302C, IAB 8/22/12), IAB 12/12/12, effective 1/16/13]
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[Filed ARC 2861C (Notice ARC 2760C, IAB 10/12/16), IAB 12/7/16, effective 1/11/17]

TITLE XI
VOCATIONAL REHABILITATION EDUCATION

CHAPTER 56
IOWA VOCATIONAL REHABILITATION SERVICES

[Prior to 9/7/88, see Public Instruction Department[670] Ch 35]

DIVISION I
SCOPE AND GENERAL PRINCIPLES

281—56.1(259) Responsibility of division. The division is responsible for providing services leading to competitive integrated employment for eligible Iowans with disabilities in accordance with Iowa Code chapter 259, the federal Rehabilitation Act of 1973 as amended, the federal Social Security Act (42 U.S.C. Section 301, et seq.), and the corresponding federal regulations.
[**ARC 1778C**, IAB 12/10/14, effective 1/14/15; **ARC 2844C**, IAB 12/7/16, effective 1/11/17]

281—56.2(259) Nondiscrimination. The division shall not discriminate on the basis of age, race, creed, color, gender, sexual orientation, gender identity, national origin, religion, duration of residency, or disability in the determination of a person's eligibility for rehabilitation services and in the provision of necessary rehabilitation services.
[**ARC 1778C**, IAB 12/10/14, effective 1/14/15; **ARC 2844C**, IAB 12/7/16, effective 1/11/17]

DIVISION II
DEFINITIONS

281—56.3(259) Definitions. For the purpose of this chapter, the indicated terms are defined as follows:

"Act" means the federal Rehabilitation Act of 1973 as amended and codified at 29 U.S.C. Section 701, et seq.

"Aggregate data" means information about one or more aspects of division job candidates, or from some specific subgroup of division job candidates, but from which personally identifiable information on any individual cannot be discerned.

"Applicant" means an individual who submits an application for vocational rehabilitation services; has completed a common intake application through a one-stop center requesting vocational rehabilitation services; has otherwise requested services from the designated state unit; or has provided information necessary to initiate an assessment to determine eligibility and priority for services; and is available to complete the assessment process.

"Appropriate modes of communication" means specialized aids and supports that enable an individual with a disability to comprehend and respond to information that is being communicated.

"Assessment for determining eligibility or in the development of an IPE" means a review of existing data and, to the extent necessary, the provision of appropriate assessment activities to obtain additional information to make a determination and to assign the priority for services assignment or development of an IPE.

"Assistive technology device" has the meaning given such term in Section 3 of the Assistive Technology Act of 1998 and means any item, piece of equipment or product system, whether acquired commercially or off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of an individual with a disability.

"Assistive technology service" has the meaning given such term in Section 3 of the Assistive Technology Act of 1998 and means any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device. Assistive technology services include:

1. Evaluating the needs of an individual with a disability, including a functional evaluation of the individual in the individual's customary environment;
2. Aiding an individual with a disability in purchasing, leasing, or otherwise providing for the acquisition of an assistive technology device;
3. Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;

4. Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;

5. Providing training or technical assistance for an individual with a disability or, if appropriate, the family members, guardians, advocates, or authorized representatives of the individual; and

6. Providing training or technical assistance for professionals (including individuals providing education and rehabilitation services), employers, or others who provide services to, employ, or are otherwise substantially involved in the major life functions of individuals with disabilities, to the extent that training or technical assistance is necessary to the achievement of an employment outcome by an individual with disabilities.

"Benefits planning" means those counseling and planning services and supports needed for individuals who, due to their disabilities, are beneficiaries of social security or supplemental security income to enhance the financial ability of the individual to participate in work, plan for or avoid an overpayment, and address their unique disability needs on a job producing a product such as an impairment-related work expense (IRWE) or a program for achieving self-support (PASS).

"Case record" means the file of personally identifiable information, whether written or electronic in form, on an individual that is collected to carry out the purposes of the division as defined in the Act and the Social Security Act. This information remains a part of the case record and is subject to these rules even when temporarily physically removed, either in whole or in part, from the file folder in which it is normally kept.

"Community rehabilitation program" means any program or service, be it private for profit or nonprofit, that is an approved vendor of the Iowa department of human services' rehabilitation Medicaid providers and that demonstrates certification of quality services from nationally recognized bodies of oversight.

"Comparable services and benefits" means services and benefits that are provided or paid for in whole or in part by other federal, state, or local public agencies, by health insurance or by employee benefits; are available to the individual at the time needed to ensure the individual's progress toward achieving an employment outcome in accordance with the individual's IPE; and commensurate to the services that the individual would otherwise receive from the DSU. For purposes of this definition, comparable benefits do not include educational awards and scholarships based on merit.

"Competitive integrated employment" means work in the competitive labor market that:

1. Is performed on a full-time or part-time basis, including self-employment, in an integrated setting and for which the job candidate is compensated at a rate that:

- Shall not be less than the higher of the rate specified in Section 6(a)(1) of the Fair Labor Standards Act of 1938 or the rate specified in the applicable state or local minimum wage law;
- Is not less than the customary rate paid by the employer for the same or similar work performed by other employees who are not individuals with disabilities and who are similarly situated in similar occupations by the same employer and who have similar training, experience, and skills; and
- Is eligible for the level of benefits provided to other employees;

2. Is at a location where the employee interacts with other persons who are not individuals with disabilities (not including supervisory personnel or individuals providing services to such employee) to the same extent that individuals who are not individuals with disabilities and who are in comparable positions interact with other persons; and

3. As appropriate, presents opportunities for advancement that are similar to those for other employees who are not individuals with disabilities who have similar positions.

"Competitive integrated work setting," with respect to the provision of services, means a setting, typically found in the community, in which applicants or eligible individuals interact with nondisabled individuals, other than nondisabled individuals who are providing services to those applicants or eligible individuals, and said interaction is consistent with the quality of interaction that would normally occur in the performance of work by the nondisabled coworkers.

"Customized employment" means competitive integrated employment, for an individual with a significant disability, that is based on an individualized determination of the strengths, needs, and interests of the individual with a significant disability; is designed to meet the specific abilities of the

individual with a disability and the business needs of the employer; and is carried out through flexible strategies.

"Department" means the department of education.

"Designated representative" means anyone the job candidate designates to represent the job candidate's interests before and within the division. The term does not necessarily mean a legal representative. The designated representative may be a parent, guardian, friend, attorney, or other designated person.

"Designated state unit" or *"DSU"* means the division of vocational rehabilitation services.

"Division" means the division of vocational rehabilitation services of the department of education.

"Employment outcome" means, with respect to an individual, entering or retaining full-time or, if appropriate, part-time competitive employment in the integrated labor market; supported employment; or any other type of employment, including self-employment, telecommuting, or business ownership, that is consistent with an individual's strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice, including satisfying the vocational outcome of customized employment.

"Extended services" means ongoing support services and other appropriate services that are needed to support and maintain an individual with a most significant disability in supported employment and that are:

1. Provided singly or in combination and are organized and made available in such a way as to assist an eligible individual in maintaining supported employment;
2. Organized or made available singly or in combination with other services for job maintenance;
3. Based on a determination of the needs of an eligible individual, as specified in the IPE;
4. Provided by an appropriate source after an individual has made the transition from support provided by the DSU; and
5. Provided to a youth with a most significant disability for no more than 48 months by the DSU when no other resource is available and not beyond the graduation date when the agreement with the department of human services applies, and until such time that the long-term funding is available.

"Family" means any individual who lives with the individual with a disability and has a vested interest in the welfare of that individual whether by marriage, birth, or choice. A family member is an individual who either (1) is a relative or guardian of an applicant or job candidate; or (2) lives in the same household as an applicant or job candidate and has a substantial interest in the well-being of the applicant or job candidate.

"Home modification" means the alteration of an already existing living unit to make it accessible or more accessible by a person with a disability who is involved with the independent living program or as necessary to achieve stable employment as part of an individualized plan for employment. The structural integrity and maintenance of the home is the responsibility of the owner. Home modifications are not provided to homes that are not structurally sound.

"Impartial hearing officer" or *"IHO"* means a person who is not an employee of the division; is not a member of the state rehabilitation advisory council; has not been involved previously in the vocational rehabilitation of the applicant or job candidate; has knowledge of the delivery of vocational rehabilitation services, the state plan and the federal and state rules and regulations governing the provision of such services; has received training in the performance of the duties of a hearing officer; and has no personal or financial interest that would be in conflict with the person's objectivity.

"Independent living services" or *"IL services"* means those items and services provided to individuals who have a significant physical, mental, or cognitive impairment and whose ability to function independently in the family or community or whose ability to obtain, maintain, or advance in employment is substantially limited, and for whom the delivery of IL services will improve their ability to function, continue functioning, or move toward functioning independently in the family or community or to continue in employment.

"Individualized plan for employment" or *"IPE"* means a plan that specifies the services needed by an eligible individual and the responsibilities of the individual with a disability and other payers and must include the financial obligation of the individual with a disability, the progress measurements, the

expected employment outcome and the timeline for achievement of the expected employment outcome and all provisions required by federal regulations.

"Individual with a most significant disability" means an individual who is seriously limited in three or more functional capacities (such as mobility, communication, self-care, self-direction, interpersonal skills, work tolerance, or work skills) in terms of an employment outcome.

"Individual with a significant disability" means an individual who has a significant physical or mental impairment that seriously limits one or more functional capacities (such as mobility, communication, self-care, self-direction, interpersonal skills, work tolerance, or work skills) in terms of an employment outcome or who is a recipient of SSD/SSI due to the individual's disability.

"Institution of higher education" has the meaning given the term in Section 102(a) of the Higher Education Act of 1965.

"Intensive services" means services only available and provided under an IPE. Intensive services do not include ancillary services, such as maintenance, transportation, benefits planning, reader, interpretation taker services, etc.

"Job candidate" means an applicant or eligible individual applying for or receiving benefits or services from any part of the division and shall include former job candidates of the division whose files or records are retained by the division.

"Job retention eligible candidate" means an individual who is at immediate risk of losing the individual's job and requires vocational rehabilitation services in order to maintain employment and thereby move directly into active status and bypass the waiting list only for those services that will allow the individual to maintain employment. After having received said service(s) or good(s), the job retention eligible individual will return to the waiting list until that point where the individual's priority of service is being served.

"Maintenance" means monetary support provided to a job candidate for expenses, such as food, shelter, and clothing, that are in excess of the normal expenses of the job candidate and that are necessitated by the job candidate's participation in the program.

"Mediation" means the act or process of using an independent third party to act as a mediator, intermediary, or conciliator to assist persons or parties in settling differences or disputes prior to pursuing formal administrative or other legal remedies.

"Menu of services" means the services provided by community partners to assist an individual with a disability in achieving an employment outcome. The services are selected and jointly agreed to by the counselor and job candidate of the division. Payments for services are made based on a fee structure that is published and updated annually, and there is no financial assessment toward the costs of these purchased services from a community rehabilitation program. The services include the following:

1. Assessment through discovery, community work-site assessment, comprehensive vocational evaluation, career exploration, or job shadowing assessment to identify a realistic vocational goal that is compatible with the individual's needs, preferences, abilities, disability, and informed choice;

2. Placement services selected by the counselor, job candidate and interested partners to prepare for and obtain employment. Placement services include the following:

- Vocational preparation, performed in a competitive integrated work environment, that enhances and improves the job candidate's ability to perform specific work, learn the necessary skills to do a specific job, minimize negative work habits and behaviors that have impeded job retention, develop skills in finding a job, and learn how to navigate transportation systems to and from work;
- Work adjustment training, performed in a competitive integrated work environment, that remedies negative work habits and behaviors, improves work tolerance, and develops strategies to improve a job candidate's ability to maintain employment;
- Job-seeking skills training that teaches the job candidate strategies necessary to find employment at the level required by the job candidate's needs;
- Job development and job follow-up that places the job candidate on a job in the community working for a business, maintains contact with the employer on the job candidate's progress, is jointly funded through the Medicaid waiver program when appropriate, and is purchased only when used in conjunction with another required service;

- Employer development that, through a job analysis, identifies for businesses the job tasks and customized training plan for the job for which the job candidate will be trained, is authorized only as a stand-alone service when the Medicaid waiver funds the job development and is purchased only when used in conjunction with another required service;
- Supported job coaching that assists the job candidate in learning job-specific skills and work habits and behaviors while employed on the job and that continues as needed after the division file is closed;
- Selected job coaching that assists the job candidate in learning job-specific skills and work habits and behaviors while employed on the job and that is purchased only when approved by the area office supervisor.

"Ongoing support services" means services that are written in the IPE; are needed to support and maintain individuals with the most significant disabilities in supported employment; are provided, at a minimum, twice monthly to make an assessment regarding the employment situation at the work site and coordinate provision of specific intensive services needed to maintain stability; are provided by skilled job trainers who accompany the individual for intensive job skill training at the work site; include social skills training, assessment and evaluation of progress, job development and retention, placement services, and follow-up services with the business and the individual's representatives; and facilitate development of natural supports or any other service(s) needed to maintain employment.

"Personal assistance services" means a range of services provided by one or more persons and designed to assist an individual with a disability to perform, on or off the job, daily living activities that the individual would typically perform if the individual did not have a disability. Such services shall be designed to increase the individual's control in life and ability to perform everyday activities on or off the job.

"Physical or mental impairment" means an impairment for which services are paid according to the department of human services' Medicaid or Medicare fee schedule and includes:

1. Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, or endocrine; or
2. Any mental or psychological disorder such as an intellectual disability, organic brain syndrome, emotional or mental illness, or specific learning disabilities; or
3. Any impairment for which an individual has a documented history of receiving special education services in both elementary and secondary school.

"Physical or mental restoration services" means:

1. Corrective surgery or therapeutic treatment that is allowed under Medicaid or Medicare and is likely, within a reasonable period of time, to correct or modify substantially a stable or slowly progressive physical or mental impairment that constitutes a substantial impediment to employment;
2. Diagnosis and treatment of a physical, mental, or cognitive disorder by qualified personnel in accordance with state licensure laws and Medicaid requirements to include:

- Dentistry;
- Nursing services;
- Necessary hospitalization (either inpatient or outpatient) in connection with surgery or treatment and clinical services;
- Drugs and supplies;
- Prosthetic and orthotic devices;
- Eyeglasses and visual services, including visual training, and the examination and services necessary for the prescription and provision of eyeglasses, contact lenses, microscopic lenses, telescopic lenses, and other special visual aids prescribed by personnel that are qualified in accordance with state licensure laws;
- Podiatry;
- Physical therapy;
- Occupational therapy;

• Speech and hearing therapy;

• Mental health services;

• Special services for the treatment of individuals with end-stage renal disease, including transplantation, dialysis, artificial kidneys, and supplies; and

• Other medical or medically related rehabilitation services.

"Plan for natural supports" means a plan, designed prior to the implementation of the supported employment program, that describes the natural supports to be used on the job; the training provided to the supervisor and mentor on the job site; the technology used in the performance of the work; the rehabilitation strategies and trainings that will be taught to the mentor in order to support and direct the job candidate on the job; the supports to be provided outside of work for the job candidate to be successful; and the methods by which the employer can connect with the job candidate's job coach and training program when the need arises.

"Postemployment services" means services that are intended to ensure that the employment outcome remains consistent with the individual's unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice. These services are available to meet the rehabilitation needs that do not require a complex and comprehensive provision of services and, thus, are limited in scope and duration.

"Potentially eligible" means students who may be in special education served under an individual education plan (IEP) or are considered to have a disability according to Section 504 of the Rehabilitation Act of 1998 and the Americans with Disabilities Act of 1992. These individuals may receive preemployment transition services but are not considered eligible for intensive services nor have they applied for services when they are potentially eligible.

"Preemployment transition services" means services provided in accordance with Section 113 of the Workforce Innovation and Opportunity Act to all students with disabilities who are in need of services and are eligible or potentially eligible for services. These services focus students and youth with disabilities on preparing for, securing, and retaining competitive integrated employment by using a variety of work-based learning strategies and work-readiness strategies combined with counseling and guidance as well as self-advocacy development. Preemployment transition services include the following:

1. Job exploration counseling;
2. Work-based learning experiences, which may include in-school or after-school opportunities, or experience outside the traditional school setting (including internships) that is provided in an integrated environment to the maximum extent possible;
3. Counseling on opportunities for enrollment in comprehensive transition or postsecondary educational programs at institutions of higher education;
4. Workplace-readiness training to develop social skills and independent living;
5. Instruction in self-advocacy, which may include peer mentoring;
6. Authorized activities to improve transition from secondary to postsecondary activities and employment outcomes; and
7. Coordinated and authorized activities to work with teachers, employers, and others interested in the transition of the student to enhance effective transition of the student with a disability from secondary to postsecondary activities and employment.

"Rehabilitation technology" means 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, employment, transportation, independent living, and recreation. The term includes rehabilitation engineering, assistive technology devices, and assistive technology services. For purposes of the rehabilitation services bureau of the DSU, the purposeful inclusion of rehabilitation technology in an IPE is for the purposes of preparing for, obtaining, maintaining, or advancing in employment.

"Residency requirement" is met by an individual who resides in the state of Iowa and is present and available for participation in a rehabilitation plan leading to competitive integrated employment.

"Satisfactory employment" means stable employment consistent with an individual's IPE and acceptable to both the individual and the employer.

"Self-employment services" means services specifically for the eligible individual who has an idea for ownership of a for-profit business, and includes technical assistance in developing proprietary skills and knowledge as well as financial assistance for business start-up that does not exceed $10,000 and requires a dollar-for-dollar match from the job candidate seeking self-employment.

"Status" means the existing condition or position of a case. The specific case statuses are as follows:

02-0 Referral/Applicant (individual requests services and signs the rights and responsibilities form);

04-0 Accepted for services (eligible), but does not meet waiting list categories being served;

08-0 Closed before acceptance (eligibility criteria cannot be met or case is closed for some other reason);

10-__ Accepted for services (eligible); substatus:

10-1 Eligible individuals in secondary education;

12-0 IPE developed, awaiting start of services;

14-0 Counseling and guidance only (counselor works with job candidate directly to reach goals through counseling and placement);

16-0 Physical and mental restoration (when such services are the most significant services called for on the IPE);

18-__ Training (when training is the most significant service called for on the IPE); substatuses are:

18-1 Training in a workshop/facility;

18-2 On-the-job training;

18-3 Vocational-technical training;

18-4 Academic training;

18-5 High school training;

18-6 Supported employment;

18-7 Other types of training not covered above (including nonsupported employment job coaching);

20-0 Ready for employment (IPE has been completed to extent possible);

22-0 Employed;

24-0 Service interrupted (IPE can no longer be continued for some reason, and no new IPE is readily obvious);

26-0 Closed rehabilitated (can only occur from Status 22-0 when job candidate has been employed in the job of closure for a minimum of 90 days);

28-0 Closed after IPE initiated (suitable employment cannot be achieved, or employment resulted without benefit of services from the division);

30-0 Closed before IPE initiated (can only occur from either Status 10-__ or 12-0 when a suitable individualized plan for employment cannot be developed or achieved or when employment resulted without benefit of services from the division);

32-0 Postemployment services;

33-__ Closed after postemployment services; substatuses are:

33-1 Individual is returned to suitable employment, or employment is otherwise stabilized;

33-2 Case reopened for comprehensive vocational rehabilitation services;

33-3 Situation has deteriorated to the point that further services would be of no benefit to individual;

38-0 Closed from Status 04-0 (individual does not meet one of the waiting list categories, and the individual no longer wants to remain on the waiting list or fails to respond when contacted because individual's name is at top of waiting list).

"Student with a disability" means an individual with a disability who is not younger than the age of 14 and is not older than the age of 21; and is eligible for, and receiving, special education or related services under the Individuals with Disabilities Education Act; or is an individual with a disability for purposes of Section 504 and meets the age requirements.

"Substantial impediment to employment" means that a physical or mental impairment (in light of attendant medical, psychological, vocational, educational, communication, and other related factors)

hinders an individual from preparing for, entering into, engaging in, or retaining competitive integrated employment consistent with the individual's abilities and capacities.

"Supported employment" means competitive integrated employment, including customized employment, or employment in an integrated work setting in which individuals are working on a short-term basis toward competitive integrated employment. Such employment is individualized and customized consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individual for whom ongoing support services for individuals with the most significant disabilities is necessary.

"Supported employment services" means ongoing support services, including customized employment, that are needed to support and maintain an individual with a most significant disability in supported employment, are provided by the division and documented for no more than 24 months, except that period may be extended if necessary in order to achieve the employment outcome as identified in the IPE, are provided singly or in combination with other services, and are organized and made available in such a way as to assist an eligible individual to achieve an employment outcome within a 24-month period of time, which may be extended based on the needs of the individual.

"Transition services" means a coordinated set of activities provided to a student and designed within an outcome-oriented process that promotes movement from school to postschool activities. Postschool activities include postsecondary education, vocational training, integrated employment (including supported employment), continuing and adult education, adult services, independent living, and community participation. The coordinated set of activities must be based upon the individual student's needs, taking into account the student's preferences and interests, and must include instruction, community experiences, the development of employment and other postschool adult living objectives, and, if appropriate, acquisition of daily living skills and functional vocational evaluation. Transition services must promote or facilitate the achievement of the employment outcome identified in the student's IPE.

"Transportation" means travel and related expenses that are necessary to enable an applicant or eligible individual to participate in a vocational rehabilitation service.

"Vocational rehabilitation services" means those services identified under an IPE and provided to individuals who have applied for and been determined eligible for services by the DSU to enable individuals with disabilities, including individuals with the most significant disabilities, to pursue meaningful careers by securing gainful competitive integrated employment commensurate with their abilities and capabilities.

"Waiting list" means the listings of eligible individuals for vocational rehabilitation services who are not in a category being served, otherwise known as "order of selection" under the Workforce Innovation and Opportunity Act of 2014.

"Workforce investment activities" means the provision of workforce development activities that creates linkages and systemic improvements so that individuals with disabilities are ensured an effective and meaningful participation in workforce innovation and opportunity activities.

"Youth with a disability" means an individual with a disability who is not younger than 14 years of age and not older than 24 years of age.

[**ARC 8806B**, IAB 6/2/10, effective 7/7/10; **ARC 1778C**, IAB 12/10/14, effective 1/14/15; **ARC 2844C**, IAB 12/7/16, effective 1/11/17]

DIVISION III
ELIGIBILITY

281—56.4(259) Individuals who are recipients of SSD/SSI. Recipients of social security disability payments or supplemental security income payments are presumed eligible as being significantly disabled and are eligible for vocational rehabilitation services if such recipients demonstrate eligibility under subrule 56.6(6) and rule 281—56.8(259). Recipients who demonstrate eligibility under subrule 56.6(6) and rule 281—56.8(259) must also demonstrate need in the employment plan under rule 281—56.9(259). Nothing in this rule automatically entitles a recipient of social security disability payments or supplemental security income payments to any good or service provided by the division.

Qualified division personnel will identify and document the individual as a recipient of social security benefits based on disability, and the determination of impediments to employment and need for services will be documented by the qualified rehabilitation counselor.
[**ARC 8806B**, IAB 6/2/10, effective 7/7/10; **ARC 1778C**, IAB 12/10/14, effective 1/14/15; **ARC 2844C**, IAB 12/7/16, effective 1/11/17]

281—56.5(259) Eligibility for vocational rehabilitation services.

56.5(1) Eligibility for vocational rehabilitation services shall be determined upon the basis of the following:

a. A determination by a qualified rehabilitation counselor that the applicant has a physical or mental impairment;

b. A determination by a qualified rehabilitation counselor that the applicant's physical or mental impairment constitutes or results in a substantial impediment to employment for the applicant;

c. A determination by a qualified vocational rehabilitation counselor that the applicant requires vocational rehabilitation services due to the applicant's disability to prepare for, secure, retain, regain, or advance in employment consistent with the applicant's unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice.

56.5(2) A presumption exists that the applicant can benefit, in terms of an employment outcome, from the provision of vocational rehabilitation services.

56.5(3) Standards for ineligibility. If the DSU determines that an applicant is ineligible for vocational rehabilitation services or determines that an individual receiving services under an IPE is no longer eligible for services, the DSU must:

a. Make the determination only after full consultation with the individual impacted or, as appropriate, the individual's representative;

b. Inform the individual in writing, supplemented with appropriate modes of communication;

c. Provide to the individual the individual's appeal or mediation rights;

d. Provide the individual information on the Iowa client assistance program (ICAP);

e. Refer the individual to other appropriate programs; and

f. Review the decision semiannually the first year, and annually thereafter, when the decision to close the file is based on findings that the individual who received services under an IPE is incapable of achieving competitive integrated employment at the time of closure.
[**ARC 1778C**, IAB 12/10/14, effective 1/14/15; **ARC 2844C**, IAB 12/7/16, effective 1/11/17]

281—56.6(259) Other eligibility and service determinations.

56.6(1) *Achievement of an employment outcome.* Any eligible individual, including an individual who is presumed eligible, must intend to achieve an employment outcome that is consistent with the applicant's unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice. The DSU is responsible for informing individuals, through the application process for services, that individuals who receive services from the DSU must intend to achieve an employment outcome. The applicant's completion of the application process for vocational rehabilitation services is sufficient evidence of the individual's intent to achieve an employment outcome.

56.6(2) *Options for IPE development.*

a. The DSU will provide information on the available options for developing the individualized plan for employment (IPE), including the option that an eligible individual or, as appropriate, the individual's representative may develop all or part of the IPE:

(1) Without assistance from the DSU or any other entity; or

(2) With assistance from:

1. A qualified vocational rehabilitation counselor employed by the DSU;
2. A qualified vocational rehabilitation counselor not employed by the DSU;
3. A representative of DSU under the guidance of a DSU vocational rehabilitation counselor;
4. A disability advocacy organization, such as the Iowa client assistance program (ICAP) or Disability Rights Iowa, or any other advocacy organization of the individual's choosing; or

5. A representative through another source that is already working with the individual, such as the individual's case manager.

b. The IPE is not approved or put into practice until it is discussed and reviewed with, revised if applicable, and approved by the vocational rehabilitation counselor employed by DSU.

c. The IPE implementation date begins on the date of the DSU counselor's signature.

d. There is no compensation for any expenses incurred while the IPE is developed with any entity not employed by the DSU.

e. If the job candidate is not on the DSU waiting list and requires some assessment services to develop the IPE, the job candidate must discuss the needs in advance with the DSU counselor and obtain prior approval if financial assistance is needed from the DSU to pay for the assessment service.

f. If the job candidate requires information from a benefits planner, the DSU can provide or arrange that assistance at any time during the development or implementation of the plan, when the job candidate is off the waiting list.

56.6(3) *Scope of services.* Vocational services for eligible individuals not on a waiting list are services described in an individualized plan for employment and are necessary to assist the eligible individual in preparing for, obtaining, retaining, regaining, or advancing in employment if the failure to advance is due to the disability, consistent with informed choice. The services include:

a. Assessment for determining eligibility and services needed for an eligible individual to achieve competitive integrated employment including, if necessary, an assessment in rehabilitation technology;

b. Counseling and guidance, which is career counseling to provide information and support services to assist the eligible individual in making informed choices about the individual's future work or career goals;

c. Referral and other services to secure needed services from other agencies and through agreements with other organizations and agencies;

d. Job-related services to facilitate the preparation for, obtaining of, and retaining of employment to include job search, job development, job placement assistance, job retention services, follow-up services and follow-along if necessary and required under the IPE;

e. Vocational and other training services that assist the eligible individual in preparing for work or an occupation identified on the IPE and include the provision of personal and vocational adjustment services, books, tools, and other training materials, except that no training services may be paid for with funds by the DSU unless maximum efforts have been made by the DSU and the individual to secure grant assistance, in whole or in part, or assistance from other sources to pay for such training;

f. Training and training materials as provided according to the fee schedule and the following provisions:

(1) The training and books and supplies that are necessary for the job candidate's satisfactory occupational adjustment.

(2) The job candidate has the mental and physical capacity to acquire a skill that the job candidate can perform in an occupation commensurate with the job candidate's abilities and limitations.

(3) The job candidate is not otherwise precluded by law from employment in the job candidate's field of training.

(4) If the costs exceed the fee schedule established for in-state training, individuals deciding to attend a training program outside the state of Iowa may do so at their own expense;

g. Physical and mental treatment may be provided to the extent that financial support is not readily available from another source, such as health insurance of the individual or a comparable service or benefit, and said treatment is essential to the progression of the individual to achieve the competitive integrated employment outcome according to the following provisions:

(1) The service is necessary for the job candidate's satisfactory occupational adjustment.

(2) The condition causing disability is relatively stable or slowly progressive.

(3) The condition is of a nature that treatment may be expected to remove, arrest, or substantially reduce the disability within a reasonable length of time.

(4) The prognosis for life and employability is favorable.

56.6(4) *Specific services requiring financial assessment.* Financial need must be established prior to provision of certain services at the division's expense and is evidenced by documents of financial income. Applicants are eligible for physical restoration, occupational licenses, customary occupational tools and equipment, training materials, maintenance and transportation (except transportation for diagnosis, guidance or placement) only on the basis of financial need and when services are not otherwise immediately available or comparable benefits and services are not available. Recipients of SSD/SSI due to their disability who are independent are not subject to a financial needs test for any services but must demonstrate eligibility under subrule 56.6(6) and rule 281—56.8(259), as well as demonstrate need in the IPE under rule 281—56.9(259).

a. For the determination of financial need, the job candidate or, in the case of a minor, the minor's parent or guardian, or family in which the individual resides, is required to provide documentation regarding all family income from any source that may be applied toward the cost of rehabilitation services, except the rehabilitation services of diagnosis, counseling, training and placement, which are provided without regard to financial need; however, the division shall not pay for more than the balance of the cost of the service minus comparable services and benefits and the individual's documented contribution. A comparable services and benefits search is required for some services. When an individual refuses to supply documentation of family income, the individual assumes 100 percent of the responsibility for the costs of rehabilitation.

b. The division shall observe the following policies in making a determination of financial need based upon the findings:

(1) All services requiring the determination of financial need are provided on the basis of supplementing the resources of the job candidate or of those responsible for the job candidate.

(2) A supervisor may grant an exception in cases where the applicant's disability caused or is directly related to financial need and where all other sources of money have been exhausted by the applicant or the parents or guardians of a minor applicant.

(3) Consideration shall be given to the job candidate's responsibility for the immediate needs and maintenance of the job candidate's dependents, and the job candidate shall be expected to reserve sufficient funds to meet the job candidate's family obligations and to provide for the family's future care, education and medical expenses.

(4) Income up to a reasonable amount should be considered and determined based on the federal poverty guidelines associated with family size, income, and exclusions.

(5) General assistance from state or federal sources is disregarded as a resource unless the assistance is a grant award for postsecondary training.

(6) Grants and scholarships based on merit, while not required to be searched for as a comparable benefit, may be considered as part of the determination of financial support of a plan when a request beyond the basic support for college is requested. Public grants and institutional grants or scholarships not based on merit are considered a comparable benefit.

56.6(5) *Areas in which exceptions shall not be granted.* Pursuant to federal law, an exception shall not be granted for any of the following requirements:

a. The eligibility requirements in rule 281—56.5(259) (i.e., presence of disability, substantial impediment to employment, need for vocational rehabilitation services).

b. The required contents of the IPE and plan of natural supports.

c. Identification of a long-term follow-up provider in supported employment cases.

d. Being in employment and in Status 22-0 consistent with federal regulations prior to Status 26-0 closure.

e. Time frames, such as the federal requirement that eligibility be determined within 60 days of an individual's application for services unless the individual has agreed to an extension.

f. Intensive services may be provided only to eligible individuals who are not on a waiting list, except for assessments which will help the division appropriately determine on which waiting list an individual belongs.

56.6(6) *Waiting list.* As required by the Act and 34 CFR Section 361.36, if the division cannot serve all eligible individuals who apply, the division shall develop and maintain a waiting list for services based on significance of disability.

a. The three categories of waiting lists are as follows, listed in order of priority to be served:

(1) Individuals with most significant disabilities;

(2) Individuals with significant disabilities; and

(3) Other individuals.

b. An individual's order of selection is determined by the waiting list and the date on which the individual applied for services from the division. All waiting lists are statewide in scope; no regional lists are to be maintained.

c. Assessment of the significance of an applicant's disability is done during the process of determining eligibility but may continue after the individual has been placed on a waiting list.

56.6(7) *Individuals who are blind.* Pursuant to rule 111—10.4(216B), individuals who meet the department for the blind's definition of "blind" are to be served primarily by the department for the blind. Individuals with multiple disabilities who also are blind may receive technical assistance and consultation services while the department for the blind provides their rehabilitation plan. Joint cases are served in the Iowa self-employment program and other contracts developed by the DSU.

56.6(8) *Students in high school.* The division may serve students in high school who may legally work in competitive integrated environments. If an applicant is in high school and is determined to be eligible for vocational rehabilitation services, such services begin before the student exits the secondary school system. The services shall not supplant services for which the secondary school is responsible and are delivered according to the memorandum of understanding in effect with the department of education.

a. When the DSU determines that a student is eligible for services, the student's place on the waiting list under subrule 56.6(6) shall be determined. If the waiting list category appropriate for the student is a category currently being served, the case record moves to a planning status and the student will work with a counselor, or other DSU representative, to develop an IPE. The student may also work with other representatives of the student's choosing to assist with the development of the IPE; however, said plan is not in effect until approved and signed by the rehabilitation counselor of record. Otherwise, the case is placed in Status 04-0, and the student's name is added to the waiting list for that category, based on the student's date of application. The IPE must be in place as required by federal regulations, unless the student has agreed to an extension or is on a waiting list. The IPE shall be developed in accordance with the standard established by the division and within the time frames established by federal regulations.

b. The counselor assigned by the division to work with the student may participate in the student's individualized education program meetings to provide consultation and technical assistance if the student is on the waiting list for services and received preemployment transition services prior to the decision on eligibility. Once a student is removed from the waiting list, the counselor may also provide vocational counseling and planning for the student and coordinate services with transition planning teams. When such services do not supplant services for which the secondary school is responsible, the division may begin to provide services specifically related to employment, such as supported employment. As needed for the student's progression toward employment, a student who is in high school or in an alternative high school and has not yet met high school graduation requirements after four years of secondary enrollment may continue to receive services that do not supplant the responsibilities of the high school. A student who is in the student's final year of high school and has made satisfactory progress and has demonstrated job-specific skills to work in the student's trained profession may receive assistance in purchasing tools to be used on the job for which the student studied.

[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

DIVISION IV
CASE MANAGEMENT

281—56.7(259) Case finding and intake. The DSU seeks to locate all disabled individuals of employable age who desire to be employed full- or part-time and may be eligible for vocational

rehabilitation services. To that end, referrals are accepted from all sources, and the DSU has established working relationships with public and private agencies in the areas of health, welfare, compensation, education, employment, rehabilitation, and other related services.

56.7(1) All new cases, whether referred to a local worker or to the division, are checked for previous information and are acknowledged promptly by letter or a personal call. Individuals with the most significant disabilities who are working at subminimum wage in a non-integrated setting are provided information about competitive integrated employment and support from the DSU, once known to the DSU, by qualified personnel and partners with the goal of assisting said individuals to pursue competitive integrated employment.

56.7(2) Referral for services from other programs. The DSU will refer applicants or eligible individuals to appropriate programs and service providers best suited to address the specific rehabilitation, independent living and employment needs of the individual with a disability. The DSU will also inform individuals with disabilities concerning the availability of employment options and vocational rehabilitation services to assist the individuals to achieve an appropriate employment outcome. The DSU will inform individuals who are in an extended employment setting that vocational rehabilitation services may be provided to them for purposes of training or to otherwise prepare them for employment using appropriate services to achieve employment in an integrated setting. The DSU will inform those who decide against pursuit of employment that services may be requested at a later date if, at that time, they choose to pursue an employment outcome. The DSU will refer the individual to a benefits planner in order that the individual will learn about work incentives. An appropriate referral is generally to federal or state programs, and to other programs carried out by other workforce development systems, that are best suited to address the specific employment needs. The DSU will provide the individual:

a. A notice of the referral;

b. Information identifying a specific point of contact at the agency to which the individual is referred;

c. Information and advice on the referral regarding the most suitable services to assist the individual.

[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

281—56.8(259) Case diagnosis used in case recording. The diagnosis of an individual with a disability is conducted by qualified personnel under state licensure laws, and the division personnel use that information as part of the eligibility requirements. The eligibility of the individual constitutes a comprehensive study of the individual, including a medical as well as a vocational impediment of the individual. Each case diagnosis is based on pertinent information, including the individual's health and physical status, intelligence, educational background and achievements, vocational aptitudes and interests, employment experience and opportunities, and personal and social adjustments. This information then is used to assess the significant impediments posed by the diagnosis toward employment to determine and identify the comprehensive services needed to prepare for, obtain, maintain, or advance in competitive integrated employment.

56.8(1) *Medical diagnosis.* As a basis for determination of eligibility and formulation of the individual's rehabilitation plan, the division secures competent medical diagnosis. When necessary, the diagnosis is, if at all practicable and appropriate, secured from recognized specialists in specific fields indicated by the general medical diagnosis. Whenever possible, the diagnosis is accompanied by recommendations as to the means and methods of restoration and by a statement of any physical or mental limitations that may exist.

56.8(2) *Current medical reports.* The division accepts a medical report in lieu of securing a new examination when the report can be relied upon to provide a sound basis for diagnosis of the physical or mental condition of the individual; is from providers or sources as listed in the case service manual; and is from an accredited or certified medical or treatment institution recognized by the state of Iowa or licensed by the department of public health or department of human services in any other state.

56.8(3) *Current health assessment.* The division requires that a current health assessment questionnaire is completed and placed in the record at the time of application if the individual with a disability does not have medical records within the last three years.

56.8(4) *Vocational impediment.* The methods of determining vocational impediments include counseling interviews with the job candidate; reports from medical, psychological, or psychiatric providers; and reports from schools, employers, social agencies, and others.

56.8(5) *Recording case data.* The division maintains a record for each case. The case record contains pertinent case information including, as a minimum, the basis for determination of eligibility, the basis justifying the plan of services and the reason for closing the case, together with a justification of the closure. A case record may not be destroyed until four years after the case has been closed. A case record documenting participation in a transitional alliance program shall be maintained until the job candidate reaches age 25 or later.

56.8(6) *Achievement of an employment outcome.* Any eligible individual, including an individual who is presumed eligible, must intend to achieve an employment outcome that is consistent with the individual's unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice. The DSU is responsible for informing individuals, through the application process for services, that individuals who receive services from the DSU must intend to achieve an employment outcome. The individual's completion of the application process for vocational rehabilitation services is sufficient evidence of the individual's intent to achieve an employment outcome.

[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

281—56.9(259) Individualized plan for employment (IPE).

56.9(1) *Content.* The IPE contains the job candidate's expected competitive integrated employment goal, the specific vocational rehabilitation services needed to reach that goal, the entity or entities that will provide those services, the method by which satisfactory progress will be evaluated, and the methods available for procuring the services. The IPE shall be developed consistent with federal regulations. The IPE must contain the specific employment outcome that is chosen by the eligible individual, consistent with the individual's unique strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice. In the case of an eligible individual who is a student in transition, the description may be a description of the student's projected postschool employment outcome in the most competitive integrated setting and the vocational rehabilitation services needed to achieve it including, as appropriate, assistive technology, personal assistance services, and the specific transition services and supports needed to achieve the projected postschool employment outcome. The IPE must contain the financial responsibility of the eligible individual as well as the methods used to evaluate progress and all corresponding responsibilities of those involved. The IPE also must contain information on how the eligible individual may access services from the Iowa client assistance program (ICAP), as well as appeal and mediation rights.

56.9(2) *Job candidate's participation and approval.* The IPE is formulated with the job candidate's participation and approval and provides for all rehabilitation services that are recognized to be necessary to fully accomplish the job candidate's vocational rehabilitation whether or not services are at the expense of the division. The IPE and progress are developed and monitored with the individual and as such must be conducted with the eligible individual. Family members may represent the individual when the individual is hospitalized and the case is interrupted until discharge, at which time the case will resume and participation requirements apply.

56.9(3) *Conditions for development of the IPE.* The basic conditions to be considered during the development of the IPE are:

a. The belief of the division that when concluded the IPE shall satisfactorily aid in the individual's achievement of competitive integrated employment; and

b. That all services are provided, unless amended and determined unnecessary. The division exercises its discretion in relation to the termination or revision of the individual's IPE when, for any reason, it becomes evident that the IPE cannot be completed.

56.9(4) *Cooperation by the job candidate.* The division requires good conduct, regular attendance and cooperation of all individuals engaged in the IPE's implementation. The division makes the following provisions for ensuring trainee cooperation: instruction through communication in the job candidate's preferred method of communication; at the beginning of the program, advising each trainee about what is expected of the trainee and that services shall continue only if the trainee's progress, attitude and conduct are satisfactory; requiring periodic progress, grade and attendance reports from the training agency; calling the trainee's attention to evidence of unsatisfactory progress or attendance before such conditions become serious; providing encouragement to the trainee to promote good work habits; and maintaining good relationships with the training agency; and other methods agreed to and determined appropriate by the qualified rehabilitation counselor, the job candidate, and representative, if applicable.

56.9(5) *Ticket to work.* The job candidate's signature on the IPE verifies the ticket assignment to the division unless otherwise directed by the job candidate.

56.9(6) *Amending the IPE.* Amendment of the IPE may be done by the individual with a disability in collaboration with a representative of the division or a qualified rehabilitation counselor or other options as described in the definition. If there are substantive changes in the employment outcome, the vocational rehabilitation services to be provided, or the service providers of the services, the changes shall not take effect until the amendment is signed by the individual with a disability or, as appropriate, the individual's representative, and by a qualified rehabilitation counselor employed by the division.

[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

DIVISION V
SERVICES

281—56.10(259) Scope of services. All necessary vocational rehabilitation services, including counseling, physical restoration, training, and placement, are made available to eligible individuals to the extent necessary to achieve their goal to be competitively employed in an integrated work setting and must be included in the IPE and agreed to by the eligible individual's counselor before the service is delivered. The division cooperates with federal and other state agencies providing vocational rehabilitation or similar services, and written agreements providing for interagency cooperation may be entered into as required by the Act at the discretion of the division. In selected instances, the division assumes responsibility for providing short periods of medical care for acute conditions arising in the course of the job candidate's rehabilitation, which if not cared for would constitute a hazard to the achievement of the rehabilitation objective unless comparable services or benefits are available to the individual. Worker's compensation assumes all medical expenses for adult job candidates that are the direct result of an injury while participating in an unpaid work experience developed by division staff and implemented under an IPE. Such injuries of students are the responsibility of the local education agency when provided under an individual education plan.

[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

281—56.11(259) Training.

56.11(1) *Duration of training.* Rehabilitation training is provided according to the actual needs of the individual. It is designed to achieve the specific employment outcome that is selected by the individual consistent with the individual's unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice.

56.11(2) *Types of training.* The types of training programs available are as follows:

a. Postsecondary training, which is training in the arts and sciences for which postsecondary credit is given and which is generally considered to be applicable toward an associate's degree, bachelor's degree, or advanced degree. All job candidates are required to file the Free Application for Federal Student Aid (FAFSA).

b. Vocational training, which includes any organized form of instruction that provides the knowledge and skills essential for performing in a vocational-technical area. Such knowledge and skills may be acquired through training in an institution, on the job, by correspondence, by tutors, through a

selection from the menu of services, by apprenticeship, or through a combination of any or all of these methods.

c. Work adjustment training, which includes any training given for any one or a combination of the following reasons:

(1) To assist individuals with disabilities, if needed, to acquire personal habits, attitudes and skills that will enable them to function effectively.

(2) To develop or increase work tolerance prior to engaging in vocational training or in employment.

(3) To develop work habits and to orient the individual to the world of work.

(4) To provide skills or techniques for the specific purpose of enabling the individual to compensate, through assistive technology, assistive technology devices, or prosthetics, for the loss of the use of a member of the body or the loss of a functional capacity.

d. Job coaching, which includes, but is not limited to, intensive work site training necessary to teach a job candidate both the job duties and job-related responsibilities.

e. Supported employment, which means competitive work in an integrated work setting with ongoing support services for individuals with the most significant disabilities for whom competitive integrated employment has not traditionally occurred or has been interrupted or intermittent as a result of significant disabilities. Supported employment is limited in accordance with federal regulations.

f. OJT, which means training on the job either as an employee or trainee of the business.

56.11(3) *Scope of training.* The division may provide training services as long as those services are part of a job candidate's IPE. Training facilities shall be selected to meet the job candidate's health, disability, and program needs. Training facilities within the state are preferred when they are comparable; those outside Iowa shall not be used unless approved for use by the vocational rehabilitation agency in the state in which the facility is located. The rate that is paid for a program outside the state remains the same as if the individual studied in the state and is in accordance with the appropriate fee schedule.

56.11(4) *Financial assistance for postsecondary training.* Calculations of financial assistance for postsecondary training are determined annually. In order for the division to continue to assist the greatest practical number of eligible job candidates, assistance shall be no less than 40 percent and no more than 70 percent of the cost of attending the least expensive in-state public institution for a course of instruction leading to an undergraduate degree. In all cases, the postsecondary institution in which the student is enrolled must be accredited by an entity recognized by the federal Department of Education as having authority to accredit postsecondary institutions.

a. Tuition and fee-based general assistance.

(1) Second year or less status. A student is considered to be in second year or less status when the student has earned fewer than 60 semester or 90 quarter credit hours in the student's present area of study or discipline; when the student is enrolled in a community college or other two-year postsecondary institution; or when the student is enrolled in a program whose terminal degree is an associate's degree but the student has not yet attained the associate's degree. For an eligible student in second year or less status, the division shall develop the fee schedule based on the least expensive per-credit-hour tuition charged by an Iowa community college. An eligible individual who changes the individual's goal after studying more than two years, but the new goal is a technical degree, is considered to be at the less-than-two-year status.

(2) Third or fourth year status. A student is considered to be in third or fourth year status if the student has earned at least 60 semester or 90 quarter credit hours or has achieved an associate's degree in the student's present area of study or discipline but has not yet earned a postsecondary baccalaureate degree. For an eligible student in third or fourth year status, the division will develop the fee schedule based on the least expensive Iowa regents institution. Students in third or fourth year status who take graduate courses are only eligible to receive the established assistance rate for third or fourth year status.

(3) Medical school. Only a student enrolled full-time in a graduate school pursuing a course of studies that will lead to a medical doctor (MD) or doctor of osteopathy (DO) degree is eligible for assistance under this paragraph. For a student who is an MD or DO candidate, the division shall pay according to the fee schedule based on the college of medicine of the University of Iowa. Students

pursuing any other graduate degree in a medical arts program may be eligible for assistance under subparagraph 56.11(4)*"a"*(5). Chiropractic school is covered under subparagraph 56.11(4)*"a"*(5).

(4) Law school. Only a student enrolled full-time in a graduate school pursuing a course of studies that will lead to a doctor of jurisprudence (JD) degree is eligible for assistance under this paragraph. For a student who is a JD candidate, the division shall pay according to the fee schedule based on the college of law of the University of Iowa. Students pursuing any other graduate degree from a law school may be eligible for assistance under subparagraph 56.11(4)*"a"*(5).

(5) Graduate or postgraduate school. Notwithstanding subparagraphs 56.11(4)*"a"*(3) and (4), for a student enrolled in a graduate or postgraduate school, the division shall pay according to the fee schedule established by the division based on the least expensive comparable graduate school at an Iowa regents institution.

(6) Distance learning (online courses). For a student enrolled in a distance learning course, the division shall pay the lesser of one of the following:

1. The actual cost of the course if the cost is less than the two-year rate on the DSU fee schedule; or

2. The rate established for a student at the student's academic level.

(7) Continuing education and non-financial aid supported programs and courses. The division shall pay the lesser of one of the following:

1. For continuing education students or a student at the four-year level attending classes at a two-year college, the actual cost of the course if the cost is less than the two-year rate on the DSU fee schedule, or

2. The rate established for a student in second year or less status if the cost of the program or course is more than the two-year rate.

(8) Out-of-state postsecondary institutions. For an eligible student who attends a postsecondary institution located outside Iowa, the division shall pay at the same rates set in this subrule.

b. Support services for postsecondary training. Unless approved as an exception by the supervisor, the amounts authorized for the items listed herein cannot exceed the amounts that would otherwise be spent on tuition and fees.

(1) Transportation shall be provided only when and to the extent that the cost is caused by participation in a program of vocational rehabilitation services.

(2) Maintenance shall be provided only to support participation in a program of vocational rehabilitation services when the job candidate has an extra expense beyond the job candidate's living expenses.

(3) Books, computers, and supplies may be provided in lieu of tuition and fees, but the amount provided therefor shall be based on the established rate on tuition and fees.

(4) Tutoring shall be provided only for courses that are part of the actual degree requirements and only when this service is not available or the legal responsibility of the training institution attended by the job candidate. Tutoring for program entrance examinations, such as the GRE, LSAT, or MCAT, is not allowed without an exception approved by the supervisor and are time limited and must be taught by qualified organizations.

(5) Unless approved as an exception, tools and equipment required for participation in a training program shall be provided in lieu of the tuition and fee amount, not to exceed the established fee rate.

(6) Unless approved as an exception, supplies for a course without which the course cannot be successfully completed shall be provided in lieu of the tuition and fee amount, not to exceed the established fee rate.

(7) Fees for certification tests that are part of a course shall be paid according to the tuition and fees standard. For certifications and licensure fees that are not part of a course, the DSU shall use the financial needs assessment form to determine the level of DSU participation, but the tests must be required by the occupation in which the job candidate plans to work as documented in the IPE.

56.11(5) *Guidance for postsecondary training.* General guidance regarding postsecondary training is available from the division's policy manual.

[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

281—56.12(259) Maintenance. The costs of maintenance shall not exceed the amount of increased expenses that the rehabilitation causes for the job candidate or the job candidate's family. Maintenance is not intended to provide relief from poverty or abject living conditions. Guidance regarding the financial support of maintenance is available from the division's policy manual.
[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

281—56.13(259) Transportation. When necessary to enable an applicant or a job candidate to participate in or receive the benefits of other vocational rehabilitation services, travel and related expenses, including expenses for training in the use of public transportation vehicles and systems, may be provided by the division. Transportation services may include the use of private or commercial conveyances (such as private automobile or van, public taxi, bus, ambulance, train, or plane) or the use of public transportation and coordination with a regional transit agency. The division shall not purchase a vehicle for a job candidate unless it is needed for self-employment, and there is no other option available to the individual. The division shall not rent a vehicle unless it is necessary for a job candidate's relocation. The division shall not pay for maintenance or repair of vehicles unless written approval of the supervisor allows for an exception.
[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

281—56.14(259) Rehabilitation technology.

56.14(1) Rehabilitation technology services are available at any point in the rehabilitation process, except to those job candidates on the waiting list. Such services include, as appropriate, an evaluation of the ability of the individual to benefit from rehabilitation technology services. Areas in which rehabilitation technology services may be of assistance include seating and positioning, augmentative communication, computer access, environmental controls, mobility equipment, and modification of the job site or home. The rehabilitation technology is that which is required by the disability. It is not considered to be a device, such as a computer, that is required to work by any individual regardless of disability as that is the responsibility of the individual or the business. The software to make the computer accessible is the rehabilitation technology, and the computer is the conduit used in all occupations.

56.14(2) Unless a written exception is approved by a supervisor, the following division contribution limits apply:

a. The division shall pay for no more than the established rate in division policy.

b. The division shall not pay anything toward the modification of a second living unit.
[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

281—56.15(259) Placement. The division not only prepares individuals with disabilities for jobs and trains them in techniques in securing their own jobs, but also accomplishes the actual placement, directly or indirectly through a service from the menu of services, of all eligible individuals with disabilities who receive rehabilitation services. Placement activities are based upon adequate evaluation and preparation of the job candidate and ordinarily include some combination of the following: evaluation of the job candidate's job readiness; development and execution of a plan for job-seeking activities; instruction in making job applications; conduct and appearance during interviews; employer contacts; registration with the state workforce development center; job analysis and modification; job coaching; employer or supervisor consultation, advisement and training; time-limited job coaching; postplacement follow-up; and relocation costs. Satisfactory employment is the objective of all division services of preparation, and placement services are an important, integral part of the overall vocational rehabilitation program. As such, in addition to the services listed herein, placement services may include the need for transportation and subsistence allowances and the purchase and acquisition of appropriate clothing, tools, equipment, and occupational licenses.
[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

281—56.16(259) Miscellaneous or auxiliary services.

56.16(1) *Family member services.* If necessary to enable an applicant or job candidate to achieve an employment outcome as defined in these rules, the division may provide any service to a family member that the division is legally able to provide to a job candidate, as long as the purpose of the service is to assess the ability of the job candidate to benefit from a program of vocational rehabilitation, prepare for, enter, and be successful in employment, or participate in a program of independent living services. Excluded are programs designed to prepare a family member to enter employment that will allow the family member to make money to support the applicant or job candidate.

56.16(2) *Interpreter and note taker services.* If deemed necessary by the division to enable a job candidate to engage in all parts of the vocational rehabilitation or independent living program process, interpreter services or note taker services shall be provided to the job candidate, unless provision of such services is the statutory responsibility of an institution or organization.

a. Interpreter services are those special communications services provided by persons qualified by training and experience to facilitate communication between division personnel and persons who are deaf or hard of hearing. Persons receiving services include deaf and hard-of-hearing persons who communicate using signs and finger spelling, as well as lip reading, writing, gestures, pictures, and other methods. Persons not fluent in the English language who could benefit from having any part of the vocational rehabilitation process translated into their major language are included. The division shall purchase sign language interpreter services, including transliterating services, from appropriately licensed interpreters only.

b. Note taker services are services provided to make written notes and summaries of orally presented material. The notes may be made from a live presentation, such as a classroom lecture, or from materials that have been taped. These services are only purchased when the law states that the presenter or institution is not statutorily responsible.

56.16(3) *Other goods and services.* Other goods and services include anything that is legal and necessary to the completion of the job candidate's IPE or independent living (IL) services plan. Under no circumstances may real estate be purchased or built with division funds. Services designed to decrease the need for future IL services can only be provided directly to IL job candidates.

[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

281—56.17(259) Facilities.

56.17(1) *Types of facilities.* It is the policy of the division to utilize any type of public or private facility that is equipped to render the required services from the menu of services of diagnosis, physical restoration, training, and placement. Facilities include public and private schools; colleges and universities; correspondence schools; agencies for personal adjustment training; business and industrial establishments for employment training; psychometric service agencies; physicians' and dentists' offices; hospitals; sanatoria and clinics; audiometric service centers; rehabilitation centers; the offices of occupational, physical and work therapists or agencies providing these services; convalescent homes; prosthetic appliance dealerships; and other similar facilities that are adequately equipped to contribute to the rehabilitation of individuals with disabilities.

56.17(2) *Standards for facilities providing specialized training or other services.* The division selects its training agencies on the basis of their ability to supply the quality of training desired. The general practice of the division is to utilize the facilities of accredited or approved colleges, universities, community rehabilitation programs, and trade and commercial schools for residence and correspondence training. The general practice of the division is to utilize community partners to deliver items from the menu of services based on the partners' ability to supply the quality of training desired and to achieve expected outcomes resulting in job placements for job candidates of the division.

56.17(3) *Facilities providing training.* Facilities selected as locations for employment training must have personnel qualified with respect to personality, knowledge and skills in the technique of instruction, have adequate equipment and instructional materials, and be willing to make definite provisions for a plan of graduated progress in the job to be learned according to an efficiently organized and supervised instructional schedule.

56.17(4) *Facilities providing personal adjustment training.* In addition to other standards set for tutorial and customized training, an important basis for selection of facilities for personal adjustment training is a sympathetic understanding of the personal adjustment needs of the individual and their importance to the job candidate's total rehabilitation.
[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

281—56.18(259) Exceptions to payment for services. As required by the Act and 34 CFR Section 361.50(c), the division shall have a method of allowing for exceptions to its rules regarding payment for services.

56.18(1) *Prohibitions.* Pursuant to federal law, the division is subject to the following prohibitions:

a. The fee schedule shall not be designed in a way that effectively denies an individual a necessary service.

b. An absolute limit on what may be provided to an individual may not be established, whether a dollar limit on specific service categories or on the total services provided to an individual may not be established.

56.18(2) *Exception process.* A request for an exception shall originate with the job candidate with assistance from qualified personnel of the division, who shall either develop a case note detailing the reason(s) why an exception is believed to be warranted or complete the appropriate form. The case note or form shall be presented to a supervisor for determination. The supervisor's determination shall be documented by the supervisor in a separate case note or in the designated place on the form.
[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

281—56.19(259) Exceptions to duration of services. As required by the Act and 34 CFR Section 361.50(d), the division shall have a method of allowing for exceptions to its rules regarding the duration of services. In order to exceed the duration of service as defined in the IPE, a job candidate must follow through on the agreed-upon IPE and related activities and keep the division informed of the job candidate's progress.
[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

281—56.20(259) Maximum rates of payment to training facilities. In no case shall the amount paid a training facility exceed the rate published, and in the case of facilities not having published rates, the amount paid the facility shall not exceed the amount paid to the facility by other public agencies for similar services. The division will maintain information necessary to justify the rates of payment made to training facilities.
[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

DIVISION VI
PURCHASING PRINCIPLES

281—56.21(259) Purchasing principles for job candidate-specific purchases.

56.21(1) The division shall follow the administrative rules for purchasing goods and services promulgated by the department of administrative services.

56.21(2) The division shall purchase only those items or models that allow a job candidate to meet the job candidate's vocational objective. The division shall not pay for additional features that exceed the requirements to meet a job candidate's vocational objective or that serve primarily to enhance the job candidate's personal life.

56.21(3) The division shall seek out and purchase the most economical item or model that meets the job candidate's vocational needs.

56.21(4) The division shall encourage all job candidates to develop strategies and savings programs to pay for replacement items/models or upgrades.

56.21(5) Items purchased for a job candidate become the property of the job candidate but may be repossessed by the division, subject to reimbursement to the job candidate for the job candidate's share of the purchase price, if the job candidate does not attain employment prior to case closure.

56.21(6) The division shall inform the job candidate that any change to planned purchases must be discussed and approved jointly before a purchase is made.

56.21(7) The division will not participate in the modification to property not owned by the job candidate or the job candidate's family.

56.21(8) When considering what item or model to purchase for a specific job candidate, the division shall in all cases consider the following factors:

a. Whether the item or model is required for the job candidate to be able to perform the essential functions of the job candidate's job.

b. Whether other parties or entities may be responsible for providing or contributing to the costs of an item.

[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

DIVISION VII
SUPERVISOR REVIEW, MEDIATION, HEARINGS, AND APPEALS

281—56.22(259) Review process. At the time of making application for rehabilitation services, and at other times throughout the rehabilitation process, all applicants and job candidates shall be informed of the right to appeal or mediation and the procedures by which to file. If an applicant or job candidate is dissatisfied with any agency decision that directly affects the applicant or job candidate, the applicant, job candidate, or designated representative may appeal that decision or request mediation. The term "appellant" shall be used to indicate the applicant, job candidate, or designated representative who initiates an appeal. The appellant may initiate the appeal process either by calling a counselor or supervisor or by filing the appropriate division appeal form, available from any counselor or supervisor of the division. If the appeal process or mediation is initiated by telephone, the counselor or supervisor who received the call must complete the appeal form to the best of that person's ability with information from the appellant. The division shall accept as an appeal or request for mediation a written letter, facsimile, or electronic mail that indicates that the applicant or job candidate desires to appeal or seek mediation. An appeal or mediation request must be filed within 90 days of notification of the disputed decision. Once the appeal form or request for mediation has been filed with the division administrator, a hearing shall be held before an impartial hearing officer (IHO) or mediator within the next 60 days unless an extension of time is mutually agreed upon or one of the parties shows good cause for an extension or one of the parties declines mediation. The appellant may request that the appeal go directly to impartial hearing, but the appellant shall be offered the opportunity for a supervisor review or mediation. The appellant may request assistance with an appeal or mediation from the Iowa client assistance program (ICAP).

[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

281—56.23(259) Supervisor review. As a first step, the appellant shall be advised that a supervisor review of the counselor's decision may be requested by notifying the counselor or supervisor in person, by telephone or by letter of the decision to appeal. If the supervisor has been involved in decisions in the case to the extent that the supervisor cannot render a fair and impartial decision or if the supervisor is not available to complete the review in a timely manner, the appeal and case file shall be forwarded to the bureau chief for review. The appellant is not required to request supervisor review as a prerequisite for appeal before an IHO; however, if a supervisor review is requested, the following steps shall be observed:

56.23(1) Upon receipt of a request for supervisor review, the supervisor shall notify all appropriate parties of the date and nature of the appeal; examine case file documentation; discuss the issues and reasons for the decision with the immediate counselor and other counselors who may have been previously involved with the case or issue; and, if necessary, meet with any or all parties to discuss the dispute.

56.23(2) The supervisor shall have ten working days from receipt of the request for supervisor review to decide the issue and notify the appellant in writing. A copy of the supervisor's decision shall be sent to all appropriate parties.

56.23(3) If the supervisor's decision is adverse to the appellant, the copy of the written decision given to the appellant shall include further appeal procedures, including notification that the appellant has ten days from the date of the letter to file further appeal. Also included shall be notice of the Iowa client assistance program (ICAP), a program within the department of human rights, commission of persons with disabilities. If ICAP determines it appropriate, ICAP provides assistance in the preparation and presentation of the appellant's case.

56.23(4) As an alternative to, but not to the exclusion of, filing for further appeal, the appellant may request mediation of the supervisor's decision, or review by the chief of the rehabilitation services bureau.

[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

281—56.24(259) Mediation. Regardless of whether a supervisor review is requested, an appellant may request resolution of the dispute through the mediation process. Mediation is also available if the appellant is dissatisfied with the supervisor's decision. If mediation is requested by the appellant and agreed to by the division, the following steps shall be observed:

56.24(1) Mediation shall be conducted by a qualified and impartial mediator, as defined in 34 CFR Section 361.5(c)(43), trained in effective mediation techniques and selected randomly by the division from a list maintained by the division.

56.24(2) The mediation shall be conducted in a timely manner at a location convenient to the parties.

56.24(3) Mediation shall not be used to delay the appellant's right to a hearing.

56.24(4) Mediation must be voluntary on the part of the appellant and the division.

56.24(5) Mediation is at no cost to the appellant.

56.24(6) All discussions and other communications that occur during the mediation process are confidential. Any offers of settlement made by either party during the mediation process are inadmissible if further appeal is sought by the appellant.

56.24(7) Existing division services provided to an appellant shall not be suspended, reduced, or terminated pending decision of the mediator, unless so requested by the appellant.

[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

281—56.25(259) Hearing before impartial hearing officer. Regardless of whether the appellant has used supervisor review or mediation or both, if the appellant requests a hearing before an IHO, the following provisions apply:

56.25(1) The division shall appoint the IHO from the pool of impartial hearing officers with whom the division has contracts. The IHO shall be assigned on a random basis or by agreement between the administrator of the division and the appellant.

56.25(2) The hearing shall be held within 20 days of the receipt of the appointment of the IHO. A written decision shall be rendered and given to the parties by the IHO within 30 days after completion of the hearing. Either or both of these time frames may be extended by mutual agreement of the parties or by a showing of good cause by one party.

56.25(3) The appellant shall be informed that the filing of an appeal confers consent for the release of the case file information to the IHO. The IHO shall have access to the case file or a copy thereof at any time following acceptance of the appointment to hear the case.

56.25(4) Within five working days after appointment, the IHO shall notify both parties in writing of the following:

a. The role of the IHO;

b. The IHO's understanding of the reasons for the appeal and the requested resolution;

c. The date, time, and place for the hearing, which shall be accessible and located as advantageously as possible for both parties but more so for the appellant;

d. The availability of the case file for review and copying in a vocational rehabilitation office prior to the hearing and how to arrange for the same (see also rule 281—56.22(259));

e. That the hearing shall be closed to the public unless the appellant specifically requests an open hearing;

f. That the appellant may present evidence and information personally, may call witnesses, may be represented by counsel or other appropriate advocate at the appellant's expense, and may examine all witnesses and other relevant sources of information and evidence;

g. The availability to the appellant of the Iowa client assistance program (ICAP) for possible assistance;

h. Information about the amount of time it will take to complete the hearing process;

i. The possibility of reimbursement of necessary travel and related expenses; and

j. The availability of interpreter and reader services for appellants not familiar with the English language and those who are deaf and the availability of transportation or attendant services for those appellants requiring such assistance.

56.25(5) Existing division services provided to an appellant shall not be suspended, reduced, or terminated pending decision of the IHO, unless so requested by the appellant.

56.25(6) The IHO shall provide a full written decision, including the findings of fact and grounds for the decision. The appellant or the division may request administrative review, and the IHO decision is submitted to the administrator of the division. Both parties may provide additional evidence not heard at the hearing for consideration for the administrative review. If no additional evidence is presented, the IHO decision stands. The division reserves the right to submit the IHO decision for administrative review whenever the IHO decision places the division in the position of violating federal law. Unless either party chooses to seek judicial review pursuant to Iowa Code chapter 17A, the decision of the IHO is final. If judicial review is sought after administrative review, the IHO's decision shall be implemented pending outcome of the judicial review.

[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

DIVISION VIII
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

281—56.26(259) Collection and maintenance of records. The division has the authority to collect and maintain records on individuals under the Act, the state plan for vocational rehabilitation services, and the Social Security Act. The acceptance of the provisions and benefits of the Rehabilitation Act, under Iowa Code section 259.1, is conditioned on the requirement that the division maintain the confidentiality of personally identifiable information and its release under certain circumstances as provided by applicable federal laws. These laws include, but are not limited to, the following:

1. The Freedom of Information Act (5 U.S.C. 552, added by P.L. 90-23 and amended by P.L. 93-502 and P.L. 94-409).
2. The Privacy Act of 1974 (5 U.S.C. 552a, added by P.L. 93-579).
3. The Drug Abuse Office and Treatment Act (21 U.S.C. 1175, added by P.L. 92-255) as amended by the Comprehensive Alcohol and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendment of 1974 (42 U.S.C. 4582, added by P.L. 93-282).
4. Section 6103 of the Internal Revenue Code (26 U.S.C. 6103) as amended by the Tax Reform Act of 1976 (P.L. 94-455).
5. The Government in the Sunshine Act (P.L. 94-409).
6. The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. 1232g, added by P.L. 93-568).

Pursuant to Iowa Code section 259.9, the state of Iowa accepts the social security system rules for the disability determination program of the division. Failure to follow the provisions of the Act can result in the loss of federal funds. The state plan provides that all personally identifiable information is confidential and may be released only with the informed written consent of the job candidate or the job candidate's representative, except as permitted by federal law. Any contrary provision in Iowa Code chapter 22 must be waived in order for the state to receive federal funds, services, and essential information for the administration of vocational rehabilitation services.

[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

281—56.27(259) Personally identifiable information. This rule describes the nature and extent of the personally identifiable information collected, maintained, and retrieved by the agency by personal identifier in record systems as defined herein. The record systems maintained by the division include the following:

56.27(1) *Personnel records.* These records contain information relating to initial application, job performance and evaluation, reprimands, grievances, notes from and reports of investigations of allegations related to improper employee behavior, and reports of hearings and outcomes of reprimands and grievances. Pursuant to Iowa Code section 22.7(11), some of the information in personnel records may be confidential.

56.27(2) *Job candidate case records.* An individual file is maintained for each person who has been referred to or has applied for the services of the division. The file contains a variety of personal information about the job candidate, which is used in the establishment of eligibility and the provision of agency services. All information is personally identifiable and is confidential.

56.27(3) *Job candidate service record computer database.* This database contains personal data items about individual job candidates. Data identifying the job candidate is confidential. Data in the aggregate is not personally identifiable and thus is not confidential.

56.27(4) *Vendor purchase records.* These are records of purchases of goods or services made for the benefit of job candidates. If the record contains the job candidate's name or other personal identifiers, the record is confidential. Lists of non-job candidate vendors, services purchased, and the costs of those services are not confidential when retrieved from a data processing system without personally identifiable information.

56.27(5) *Records and transcripts of hearings or client appeals.* These records contain personally identifiable information about a client's case, appeal from or for some action, and the decision that has been rendered. The personally identifiable information is confidential. Some of the information is maintained in an index provided for in Iowa Code section 17A.3(1)*"d."* Information is available after confidential personally identifiable information is deleted.

56.27(6) *All computer databases of client and applicant names and other identifiers.* The data processing system contains client status records organized by a variety of personal identifiers. These records are confidential as long as any personally identifiable information is present.

56.27(7) *All computer-generated reports that contain personally identifiable information.* The division may choose to draw or generate from a data processing system reports that contain information or an identifier which would allow the identification of an individual client or clients. This material is for internal division use only and is confidential.

[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

281—56.28(259) Other groups of records routinely available for public inspection. This rule describes groups of records maintained by the division other than record systems. These records are routinely available to the public, with the exception of parts of the records that contain confidential information. This rule generally describes the nature of the records, the type of information contained therein, and whether the records are confidential in whole or in part.

56.28(1) Rule making. Rule-making records, including public comments on proposed rules, are not confidential.

56.28(2) Council and commission records. Agendas, minutes, and materials presented to any council or commission required under the Act are available to the public with the exception of those records that are exempt from disclosure under Iowa Code section 21.5. Council and commission records are available from the main office of the division at 510 E. 12th Street, Des Moines, Iowa 50319.

56.28(3) Publications. News releases, annual reports, project reports, agency newsletters, and other publications are available from the main office of the division at 510 E. 12th Street, Des Moines, Iowa, 50319. Brochures describing various division programs are also available at local offices of the division.

56.28(4) Statistical reports. Periodic reports of statistical information on expenditures, numbers and types of case closures, and aggregate data on various client characteristics are compiled as needed for agency administration or as required by the federal funding source and are available to the public.

56.28(5) Grants. Records of persons receiving grants from division services are available through the main office of the division. Grant records contain information about grantees and may contain information about employees of a grantee that has been collected pursuant to federal requirements.

56.28(6) Published materials. The division uses many legal and technical publications, which may be inspected by the public upon request. Some of these materials may be protected by copyright law.

56.28(7) Policy manuals. Manuals containing the policies and procedures for programs administered by the division are available in every office of the division. Subscriptions to all or some of the manuals are available at the cost of production and handling. Requests for subscription information should be addressed to Vocational Rehabilitation Services Division, 510 E. 12th Street, Des Moines, Iowa 50319.

56.28(8) Operating expense records. The division maintains records of the expense of operation of the division, including records related to office rent, employee travel expenses, and costs of supplies and postage, all of which are available to the public.

56.28(9) Training records. Lists of training programs, the persons approved to attend, and associated costs are maintained in these records, which are available to the public.

56.28(10) Facility surveys. Records of division reviews of facilities providing services to the division are maintained and used to determine the current acceptable fee schedule. Information about individuals may be included in these records; therefore, parts of the records may be confidential.

56.28(11) All other records that are not exempted from disclosure by law.

[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

DIVISION IX
STATE REHABILITATION COUNCIL

281—56.29(259) State rehabilitation council.

56.29(1) *Composition.* The state rehabilitation council shall be composed of at least 15 members, appointed by the governor. A majority of the council members must be individuals with disabilities who are not employed by the division. The appointing authority must select members of the council after soliciting recommendations from representatives of organizations representing a broad range of individuals with disabilities and organizations interested in individuals with disabilities. In selecting members, the appointing authority must consider, to the greatest extent practicable, the extent to which minority populations are represented on the council. A majority of members must be individuals with disabilities who meet the requirements of 34 CFR Section 361.5(c)(28) and are not employed by the designated state unit. The council members shall include the following:

a. At least one representative of the statewide independent living council, who must be the chairperson or other designee of the statewide independent living council;

b. At least one representative of a parent training and information center established pursuant to Section 682(a) of the Individuals with Disabilities Education Act;

c. At least one representative of the client assistance program established under 34 CFR Part 370, who must be the director or other individual recommended by the client assistance program;

d. At least one qualified vocational rehabilitation counselor with knowledge of and experience with vocational rehabilitation programs who serves as an ex officio, nonvoting member of the council if employed by the division;

e. At least one representative of community rehabilitation program service providers;

f. Four representatives of business, industry, and labor;

g. Representatives of disability groups that include a cross section of:

(1) Individuals with physical, cognitive, sensory, and mental disabilities; and

(2) Representatives of individuals with disabilities who have difficulty representing themselves or are unable, due to their disabilities, to represent themselves;

h. Current or former applicants for, or recipients of, vocational rehabilitation services;

i. At least one representative of the state educational agency responsible for the public education of students with disabilities who are eligible to receive services under the Rehabilitation Act of 1973, as amended, and Part B of the Individuals with Disabilities Education Act;

j. At least one representative of the Iowa workforce development board; and

k. The director of the division, who serves as an ex officio, nonvoting member of the council.

56.29(2) *Chairperson.* The chairperson must be selected by the members of the council from among the voting members of the council.

56.29(3) *Terms.* Each member of the council shall be appointed for a term of no more than three years. Each member of the council, other than the representative of the client assistance program, shall serve for no more than two consecutive full terms. A member appointed to fill a vacancy occurring prior to the end of the term for which the predecessor was appointed must be appointed for the remainder of the predecessor's term and may serve one additional three-year term. The terms of service of the members initially appointed must be for a varied number of years to ensure that terms expire on a staggered basis.

56.29(4) *Vacancies.* The governor shall fill a vacancy in council membership.

56.29(5) *Functions.* The council must, after consulting with the state workforce development board:

a. Review, analyze, and advise the designated state unit regarding the designated state unit's responsibilities, particularly responsibilities related to:

(1) Eligibility, including order of selection;

(2) The extent, scope, and effectiveness of services provided; and

(3) Functions performed by state agencies that affect or potentially affect the ability of individuals with disabilities in achieving employment outcomes;

b. In partnership with the designated state unit:

(1) Develop, agree to, and review state goals and priorities in accordance with 34 CFR Section 361.29(c); and

(2) Evaluate the effectiveness of the vocational rehabilitation program and submit reports of progress to the Secretary of Education in accordance with 34 CFR Section 361.29(e);

c. Advise the designated state agency and the designated state unit regarding activities carried out under this part and assist in the preparation of the vocational rehabilitation services portion of the unified or combined state plan and amendments to the plan, applications, reports, needs assessments, and evaluations;

d. To the extent feasible, conduct a review and analysis of the effectiveness of, and consumer satisfaction with:

(1) The functions performed by the designated state agency;

(2) The vocational rehabilitation services provided by state agencies and other public and private entities responsible for providing vocational rehabilitation services to individuals with disabilities under the Rehabilitation Act of 1973, as amended; and

(3) The employment outcomes achieved by eligible individuals receiving services under 34 CFR Part 361, including the availability of health and other employment benefits in connection with those employment outcomes;

e. Prepare and submit to the governor and to the Secretary of Education no later than 90 days after the end of the federal fiscal year an annual report on the status of vocational rehabilitation programs operated within the state and make the report available to the public through appropriate modes of communication;

f. To avoid duplication of efforts and enhance the number of individuals served, coordinate activities with the activities of other councils within the state, including the statewide independent living council, the advisory panel established under Section 612(a)(21) of the Individuals with Disabilities Education Act, the state developmental disabilities planning council, the state mental health planning council, and the state workforce development board, and with the activities of entities carrying out programs under the Assistive Technology Act of 1998;

g. Provide for coordination and the establishment of working relationships between the designated state agency and the statewide independent living council and centers for independent living within the state; and

h. Perform other comparable functions, consistent with the purpose of 34 CFR Part 361, as the council determines to be appropriate, that are comparable to the other functions performed by the council.

56.29(6) *Meetings.* The council must convene at least four meetings a year. The meetings must be publicly announced, open, and accessible to the general public, including individuals with disabilities,

unless there is a valid reason for an executive session. The council's meetings are subject to Iowa Code chapter 21, the open meetings law.

56.29(7) *Forums or hearings.* The council shall conduct forums or hearings, as appropriate, that are publicly announced, open, and accessible to the public, including individuals with disabilities.

56.29(8) *Conflict of interest.* No member of the council may cast a vote on any matter that would provide direct financial benefit to the member or the member's organization or otherwise give the appearance of a conflict of interest under state law.

Rule 281—56.29(259) is intended to implement 34 CFR Sections 361.16 and 361.17.

[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

DIVISION X
IOWA SELF-EMPLOYMENT PROGRAM
(A/K/A ENTREPRENEURS WITH DISABILITIES PROGRAM)

281—56.30(259) Purpose. The division of vocational rehabilitation services works in collaboration with the Iowa department for the blind to administer the Iowa self-employment (ISE) program. The purpose of the program is to provide business development funds in the form of technical assistance (up to $10,000) and financial assistance (up to $10,000) to qualified Iowans with disabilities who start, expand, or acquire a business within the state of Iowa. Actual assistance is based on the requirements of the business, not to exceed the technical assistance and financial assistance limits.

[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

281—56.31(259) Program requirements. Clients of the division or the department for the blind may apply for the program. All of the following conditions are also applicable:

1. The division may limit or deny ISE assistance to an applicant who has previously received educational or training equipment from the division through another rehabilitation program when such equipment could be used in the applicant's proposed business.
2. Any equipment purchased for the applicant under this program that is no longer used by the applicant may be returned to the division, at the discretion of the division.
3. An applicant must demonstrate that the applicant has at least 51 percent ownership in a for-profit business that is actively owned, operated, and managed in Iowa.
4. Recommendation for and approval of financial assistance is based upon acceptance of a business plan feasibility study and documentation of the applicant's ability to match dollar-for-dollar the amount of funds requested.
5. In order to receive financial support from the ISE program, the applicant's business plan feasibility study must result in self-sufficiency for the applicant as measured by earnings that equal or exceed 80 percent of substantial gainful activity.
6. The division cannot support the purchase of real estate or improvements to real estate.
7. The division cannot provide funding to be used as a cash infusion, for personal or business loan repayments, or for personal or business credit card debt.
8. The division may deny ISE assistance to an applicant who desires to start, expand, or acquire any of the following types of businesses:

- A hobby or similar activity that does not produce income at the level required for self-sufficiency;
- A business venture that is speculative in nature or considered high risk by the Better Business Bureau or similar organization;
- A business registered with the federal Internal Revenue Service as a Section 501(c)(3) entity or other entity set up deliberately to be not for profit;
- A business that is not fully compliant with all local, state, and federal zoning requirements and all other applicable local, state, and federal requirements;
- A multitiered marketing business.

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281—56.32(259) Application procedure.

56.32(1) *Application.* Application materials for the program are available from the division and the department for the blind.

56.32(2) *Submittal.* Completed applications shall be submitted to a counselor employed by the division or the department for the blind.

56.32(3) *Review.* Applications will be forwarded to a business development specialist employed by the division for review. Approval of technical assistance funding is based upon the results of a business plan feasibility study. If the application is for financial assistance only, a business plan feasibility study will be required at the time of submission of the application. Approval of financial assistance funding is based upon acceptance of a business plan feasibility study and documentation of the applicant's ability to match dollar-for-dollar the amount of funds requested.

56.32(4) *Funding.* Before the division will provide funding for a small business, the job candidate must complete an in-depth study about the business the job candidate intends to start and must demonstrate that the business is feasible.

56.32(5) *Appeal.* If an application is denied, an applicant may appeal the decision to the division or the department for the blind. An appeal shall be consistent with the appeal processes of the division or the department for the blind.

[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

281—56.33(259) Award of technical assistance funds.

56.33(1) *Awards.* Technical assistance funds may be used for specialized consulting services as determined necessary by the counselor, the business development specialist, and the job candidate. Technical assistance funds may be awarded, based on need, up to a maximum of $10,000 per applicant. Specialized technical assistance may include, but is not limited to, engineering, legal, accounting, and computer services and other consulting services that require specialized education and training.

56.33(2) *Technical assistance.* When technical assistance is needed for specialized services beyond the expertise of the business development specialist, technical assistance will be provided to assist the job candidate.

56.33(3) *Technical assistance contracts.* The division shall negotiate contracts with qualified consultants for delivery of services to an applicant if specialized services are deemed necessary. The contracts shall state hourly fees for services, the type of service to be provided, and a timeline for delivery of services. Authorization of payment will be made by a counselor employed by the division or the department for the blind based upon the negotiated rate as noted in the contract. A copy of each contract shall be filed with the division.

56.33(4) *Consultants.* Applicants will be provided a list of qualified business consultants by the business development specialist if specialized consultation services are necessary. The selection of the consultant(s) shall be the responsibility of the applicant.

56.33(5) *Case management.* The business development specialist or counselor will be available as needed for direct consultation to each applicant to ensure that quality services for business planning are provided in a timely manner.

[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

281—56.34(259) Business plan feasibility study procedure. Information and materials are available from the division and the department for the blind. The job candidate shall submit the job candidate's business plan feasibility study to the job candidate's counselor if the study is completed at the time application is made or to the business development specialist if the business plan feasibility study is completed after application approval. The business development specialist is available to guide and assist in the analysis of the feasibility study.

[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

281—56.35(259) Award of financial assistance funds.

56.35(1) *Awards.* Following the business development specialist's review of the business plan feasibility study, the business development specialist will issue a recommendation to support or not

to support the proposed business venture. The counselor shall make a decision regarding approval or denial of the recommendation. If the plan is approved, the job candidate and counselor will review conditions of the financial assistance award and sign the appropriate forms of acknowledgment.

a. Financial assistance funds may be awarded, based on need, up to $10,000 after approval of a business plan feasibility study and evidence of business need or evidence of business progression. Before receiving financial assistance, the job candidate must demonstrate a dollar-for-dollar match based on the amount of funding needed. The match may be provided through approved existing business assets, cash, conventional financing or other approved sources.

b. Financial assistance funds may be approved for, but are not limited to: equipment, tools, printing of marketing materials, advertising, rent (up to six months), direct-mail postage, raw materials, inventory, insurance (up to six months), and other approved start-up, expansion, or acquisition costs.

56.35(2) *Award process.* The amount that may be recommended by the business development specialist and approved by the counselor shall be provided when there is a need. Recipients of financial assistance must demonstrate ongoing cooperation by providing the business development specialist with financial information needed to assess business progress before additional funds are expended.

56.35(3) *Financial assistance contracts.* Contracts for financial assistance funds shall be the responsibility of the division and will be consistent with the authorized use of Title I vocational rehabilitation funds and policy.

56.35(4) *Vendors.* Procurement of goods or services shall follow procedures established by the department of administrative services. The type of goods or services to be obtained, as well as a timeline for delivery of such, shall be stated by the vendor and agreed upon by the division. Authorization for goods or services shall be made by a counselor employed by the division or the department for the blind based upon the negotiated rate and terms as noted in the contract. A copy of each contract shall be filed with the division. Approval for payment of authorized goods or services shall be made by authorized division personnel.

[**ARC 2844C**, IAB 12/7/16, effective 1/11/17]

These rules are intended to implement Iowa Code chapter 259, the federal Rehabilitation Act of 1973 as amended, the federal Social Security Act (42 U.S.C. Section 301 et seq.), and 2008 Iowa Acts, Senate File 2101.

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CHAPTER 62
STATE STANDARDS FOR PROGRESSION IN READING

281—62.1(256,279) Purpose. The purpose of this chapter is to implement Iowa Code section 279.68. All rules in this chapter shall be construed and applied to meet the following standard: all actions under this chapter must provide reasonable expectation that a student's progress toward reading proficiency is sufficient to master appropriate grade four level reading skills prior to the student's promotion to grade four.

[**ARC 1331C**, IAB 2/19/14, effective 3/26/14]

281—62.2(256,279) Assessment of reading proficiency. All school districts shall assess reading proficiency of all students, as required by this rule.

62.2(1) *Assessment at beginning of school year.* A school district shall assess all students enrolled in kindergarten through grade three at the beginning of each school year for the students' level of reading or reading readiness.

62.2(2) *Subsequent assessments throughout school year.* A school district shall provide to all students additional, brief assessments of reading achievement in a manner required by the department, using assessments that meet the standards described in subrule 62.2(5).

62.2(3) *Progress-monitoring instruments.* For students identified as being persistently at risk in reading, as well as students who are becoming persistently at risk in reading, a school district shall monitor the students' progress in reading with instruments that meet the standards in subrule 62.2(5), in at least a frequency required by the department.

62.2(4) *Statewide or locally determined assessments.* Assessments may be locally determined or statewide, including an annual standard-based assessment, provided that all assessments for purposes of implementing this chapter meet the standards described in subrule 62.2(5).

62.2(5) *Standards for approval for assessments.* Any assessment of reading or reading readiness required by this rule and used to implement this chapter shall meet the following minimum standards before use by a school district.

a. Standards for all assessments. Any assessment used under this chapter, including instruments described in paragraphs 62.2(5)*"b"* and *"c,"* shall meet department-adopted minimum standards for reliability and validity, at the appropriate grade level and for the skills assessed. In addition, all assessments must have information available concerning administration time per student, access to student data after completion, and amount of teacher training required.

b. Standards for universal-screening instruments. Any assessment used for universal-screening purposes under this chapter shall meet department-adopted minimum standards for the following statistical measures: area under the curve and specificity/sensitivity.

c. Standards for progress-monitoring instruments. Any assessment used for progress-monitoring purposes under this chapter shall meet department-adopted standards for number of forms of demonstrated equivalence and for the following statistical measure: reliability of slope.

d. Department publication of approved assessments. The department shall annually publish or update a list of assessments approved pursuant to this subrule. Approved assessments will have a demonstrated ability to predict future reading performance.

62.2(6) *Basic levels of reading proficiency on approved assessments.* The department shall determine benchmarks for basic levels of reading proficiency to be used with approved assessments based on the ability to predict meaningful future outcomes of a student's reading performance that is sufficient to master appropriate grade four reading skills prior to the student's promotion to grade four.

62.2(7) *Assessment measures.* Assessments administered to implement this chapter, when taken as a whole, shall measure phonemic awareness, phonics, fluency, vocabulary, and comprehension.

62.2(8) *Noncompliant assessments.* Assessments that do not meet the requirements of this rule shall not be used by any school district to implement this chapter.

[**ARC 1331C**, IAB 2/19/14, effective 3/26/14; **ARC 2862C**, IAB 12/7/16, effective 1/11/17]

281—62.3(256,279) Tools for evaluating and reevaluating reading proficiency. The department identifies the following attributes of tools that may be used in evaluating and reevaluating reading proficiency.

62.3(1) *Locally determined or statewide assessments.* In evaluating and reevaluating students who are or may be at risk or persistently at risk in reading, school districts shall use assessments that meet the standards referenced in subrule 62.2(5).

62.3(2) *Alternative assessments.* If a school district determines, based on the clear and unique facts of a particular student's case, that a particular student requires an alternative assessment to determine proficiency in reading, in addition to the assessments referred to in rule 281—62.2(256,279) and subrule 62.3(1), the alternative assessment shall be founded on scientifically based research and shall be reasonably calculated to provide equivalent information about the student's reading, in addition to information provided by the assessments referred to in rule 281—62.2(256,279) and subrule 62.3(1).

62.3(3) *Portfolio reviews.* School districts may review a portfolio of a student's work to determine reading proficiency. Portfolio reviews must be conducted using standard review criteria that are founded on scientifically based research. A portfolio review may be used along with assessments required in rule 281—62.2(256,279) and subrule 62.3(1) but shall not be used in lieu of such assessments. The department shall maintain a list of portfolio review criteria that are adequate under this subrule.

62.3(4) *Teacher observation.* A student may initially be identified as being persistently at risk in reading proficiency based on teacher observation. A teacher observation under this subrule shall be based on department-approved observation criteria. Teacher observation shall not be used to determine that a student continues to be persistently at risk in reading.

62.3(5) *Other tools.* The department may identify additional tools for use in evaluating and reevaluating reading proficiency, so long as those tools are founded on scientifically based research.

62.3(6) *Alternate assessment.* If an individual with a disability has been determined to require an alternate assessment aligned to alternate academic achievement standards in reading, pursuant to rule 281—41.320(256B,34CFR300), that individual shall receive such alternate assessment. The progress monitoring required by the alternate assessment in reading required for such an individual shall be deemed to satisfy the universal screening and progress monitoring requirements of rule 281—62.2(256,279).

62.3(7) *Noncompliant tools.* Tools that do not meet the requirements of this rule shall not be used by any school district to implement this chapter.

[**ARC 1331C**, IAB 2/19/14, effective 3/26/14; **ARC 2862C**, IAB 12/7/16, effective 1/11/17]

281—62.4(256,279) Identification of a student as being persistently at risk in reading. A school district shall follow this rule in determining whether a student in kindergarten through grade three is persistently at risk in reading.

62.4(1) *Definition of "persistently at risk in reading."* A school district shall determine that a student is "persistently at risk in reading" if, based on the requirements of this chapter, the student has not met the grade-level benchmarks on two consecutive screening assessments administered pursuant to this chapter. A student is "at risk in reading" if the student did not meet the grade-level benchmark for one of the two most recent screening assessments administered pursuant to this chapter.

62.4(2) *Determination of a persistent risk in reading.*

a. In initially determining whether a student is persistently at risk in reading as defined in subrule 62.4(1), the school district shall consider assessments referred to in rule 281—62.2(256,279) and subrule 62.3(1) or teacher observations that meet the criteria referenced in subrule 62.3(4).

b. In determining whether a student continues to be persistently at risk in reading, a school district shall consider assessments referred to in rule 281—62.2(256,279) and subrule 62.3(1), with specific attention given to progress-monitoring results under subrule 62.2(3).

62.4(3) *Services offered to all students who are persistently at risk in reading.* A school district shall provide intensive reading instruction to any student who is persistently at risk in reading, as defined in subrule 62.4(1). A school district shall continue to provide the student with intensive reading instruction until the student is reading at grade level, as determined by the student's consistently

proficient performance on valid and reliable measures of reading ability that meet the requirements of rule 281—62.2(256,279). All services provided under this subrule shall comply with rule 281—62.6(256,279).

62.4(4) *Notice to parents.* The parent or guardian of any student in kindergarten through grade three who is persistently at risk in reading, as defined in subrule 62.4(1), shall be notified regularly in writing and shall be provided all of the following:

a. A description of the services currently provided to the child;

b. A description of the proposed supplemental instructional services and supports that the school district will provide to the child that are designed to remediate the identified area or areas in which the student is persistently at risk in reading;

c. Strategies for parents and guardians to use in helping the student read proficiently, including but not limited to the promotion of parent-guided home reading; and

d. Regular updates regarding the student's progress toward reaching or exceeding the targeted level of reading proficiency.

[**ARC 1331C**, IAB 2/19/14, effective 3/26/14; **ARC 2862C**, IAB 12/7/16, effective 1/11/17]

281—62.5(256,279) Intensive summer reading program.

62.5(1) *General.* Beginning May 1, 2018, unless the school district is granted a waiver pursuant to subrule 62.5(5), if a student is persistently at risk in reading by the end of grade three and is not proficient in reading on a statewide assessment of reading administered pursuant to Iowa Code section 256.7(21), the school district shall notify the student's parent or guardian that the parent or guardian may enroll the student in an intensive summer reading program offered in accordance with this rule.

62.5(2) *Parent or guardian does not enroll child in intensive summer reading program.* If the parent or guardian does not enroll the student in the intensive summer reading program and the student is ineligible for the good-cause exemption under rule 281—62.8(256,279), the student shall be retained in grade three pursuant to rule 281—62.7(256,279).

62.5(3) *Student exempt from or completes program and is not reading proficiently.* If the student is exempt from participating in an intensive summer reading program for good cause pursuant to rule 281—62.8(256,279) or completes the intensive summer reading program but is not reading proficiently upon completion of the program as determined under subrule 62.4(2), the student may be promoted to grade four, but the school district shall continue to provide the student with intensive reading instruction pursuant to subrule 62.4(3) until the student is reading proficiently, as demonstrated by scores on locally determined or statewide assessments pursuant to subrule 62.4(2).

62.5(4) *Nature of intensive summer reading program.* The intensive summer reading program offered by a school district shall comply with the program criteria and guidelines for implementation contained in 281—Chapter 61.

62.5(5) *Waiver of intensive summer reading program.* The department may grant a school district a waiver of the requirement to offer an intensive summer reading program for the summer of 2018 only. A school district must demonstrate good cause and that the requested waiver is in keeping with the objectives of Iowa Code section 279.68 and these rules.

[**ARC 1331C**, IAB 2/19/14, effective 3/26/14; **ARC 2862C**, IAB 12/7/16, effective 1/11/17]

281—62.6(256,279) Successful progression for early readers. Each school district shall provide the following.

62.6(1) *Intensive instructional services.* A school district shall provide students who are persistently at risk in reading under subrule 62.4(2) with intensive instructional services and supports, free of charge, to remediate the areas in which students are not proficient in reading. The intensive instructional services are further described in subrule 62.6(2).

a. Intensive instructional services under this subrule shall include a minimum of 90 minutes daily of scientific research-based reading instruction, which shall be core instruction.

b. In addition to the instruction described in paragraph 62.6(1)*"a,"* a school district shall prescribe other strategies, which may include but are not limited to the following:

(1) Small group instruction.

(2) Reduced teacher-student ratios.
(3) More frequent progress monitoring.
(4) Tutoring or mentoring.
(5) Extended school day, week, or year.
(6) Summer reading programs.

62.6(2) *Reading enhancement and acceleration development initiative.* The intensive instructional services described in subrule 62.6(1) shall be provided to all students in kindergarten through grade three who are identified as being persistently at risk in reading, as determined pursuant to subrule 62.4(2). The services shall meet the following requirements:

a. A school district shall provide intensive instructional services during regular school hours, in addition to the regular reading instruction.

b. A school district shall provide a reading curriculum that meets the standards of subrule 62.6(3).

62.6(3) *Reading curriculum for students who are persistently at risk in reading.* A curriculum that does not meet the standards of this subrule shall not be used to implement this chapter. To implement this subrule, a school district shall provide a curriculum that meets the following guidelines and specifications:

a. Assists students assessed as persistently at risk in reading to develop the skills to read at grade level. Assistance shall include but not be limited to strategies that formally address dyslexia, when appropriate. For purposes of this paragraph, "dyslexia" means a specific and significant impairment in the development of reading, including but not limited to phonemic awareness, phonics, fluency, vocabulary, and comprehension, that is not solely accounted for by intellectual disability, sensory disability or impairment, or lack of appropriate instruction.

b. Provides skill development in phonemic awareness, phonics, fluency, vocabulary, and comprehension.

c. Is supported by scientifically based research in reading.

d. Is implemented by certified instructional staff with appropriate training and professional development. Such training and professional development shall meet the requirements of rule 281—83.6(284).

e. Is implemented by certified instructional staff with fidelity, which shall meet such standards for fidelity of implementation that the department may adopt.

f. Includes a scientifically based and reliable assessment, which shall meet the requirements of rule 281—62.1(256,279).

g. Provides initial and ongoing analysis of each student's reading progress, which shall meet the requirements of rule 281—62.1(256,279), with notice provided to parents pursuant to subrule 62.6(4).

h. Is implemented during regular school hours.

i. Provides a curriculum in core academic subjects to assist the student in maintaining or meeting proficiency levels for the appropriate grade in all academic subjects.

62.6(4) *Parent notice, involvement and support.* At a minimum and in addition to other requirements of this chapter, school districts shall provide the following to all parents or guardians of students who are persistently at risk in reading:

a. At regular intervals, a school district shall apprise the parent or guardian of academic and other progress being made by the student and give the parent or guardian other useful information.

b. In addition to required reading enhancement and acceleration strategies provided to students, a school district shall provide parents or guardians of students who are persistently at risk in reading under subrule 62.4(2) with a plan outlined in a parental contract, including participation in regular parent-guided home reading.

62.6(5) *Report to the department.* Each school district shall report to the department the specific intensive reading interventions and supports implemented by the school district pursuant to this chapter. The department shall annually prescribe the components of required or requested reports.

62.6(6) *Rule of construction: students who are at risk in reading.* Subject to paragraphs 62.6(6)*"a"* and *"b,"* school districts may voluntarily provide additional services and interventions to students who are "at risk in reading" as defined in subrule 62.4(1).

a. School districts must provide progress monitoring to students who are "at risk in reading."

b. If a student who was previously "persistently at risk" and is currently identified as "at risk" and falls below the grade-level benchmark on a locally determined number of progress monitoring probes, the student must be provided services under this rule until the next screening assessment administered pursuant to this chapter.

[**ARC 1331C**, IAB 2/19/14, effective 3/26/14; **ARC 2862C**, IAB 12/7/16, effective 1/11/17]

281—62.7(256,279) Promotion to grade four.

62.7(1) *General.* In determining whether to promote a student in grade three to grade four, a school district shall place significant weight on any area that is not yet remediated in which the student is persistently at risk in reading, as identified pursuant to subrule 62.4(2).

62.7(2) *Mandatory retention.* A student described in subrule 62.5(2) shall be retained pursuant to this rule.

62.7(3) *Additional factors.* In addition to the significant weight required by subrule 62.7(1), the school district shall also weigh the student's progress in other subject areas, as well as the student's overall intellectual, physical, emotional, and social development.

62.7(4) *Consultation with parent or guardian.* A decision to retain a student in grade three shall be made only after direct personal consultation with the student's parent or guardian.

62.7(5) *Plan of action required.* A decision to retain a student in grade three shall be made only after the formulation of a specific plan of action to address the student's reading skills until the student is reading at grade level.

[**ARC 1331C**, IAB 2/19/14, effective 3/26/14; **ARC 2862C**, IAB 12/7/16, effective 1/11/17]

281—62.8(256,279) Good-cause exemption. A school district shall exempt students from the retention requirements of rule 281—62.7(256,279) and intensive summer reading program requirements of rule 281—62.5(256,279) for good cause.

62.8(1) *"Good cause" defined.* Good-cause exemptions shall be limited to the following:

a. Limited English proficient students who have had less than two years of instruction in an English language learners program.

b. Students requiring special education whose individualized education program indicates that participation in a locally determined or statewide assessment required by this chapter is not appropriate, consistent with the requirements of rules adopted by the state board of education for the administration of Iowa Code chapter 256B.

c. Students who demonstrate an acceptable level of performance on an alternative performance measure approved pursuant to subrule 62.3(2).

d. Students who demonstrate mastery through a student portfolio under alternative performance measures approved pursuant to subrule 62.3(3).

e. Students who have received intensive remediation in reading for two or more years but who are still persistently at risk in reading and who were previously retained in kindergarten, grade one, grade two, or grade three. Intensive reading instruction for students so promoted must include an altered instructional day that includes specialized diagnostic information and specific reading strategies for each student. The school district shall assist attendance centers and teachers to implement reading strategies that research has shown to be successful in improving reading among low-performing readers.

62.8(2) *Additional documentation required.* For students described in paragraphs 62.8(1)*"c"* and *"d,"* requests for good-cause exemptions from the retention requirement of subrule 62.5(2) and rule 281—62.7(256,279) shall include documentation from the student's teacher to the school principal that indicates that the promotion of the student is appropriate and is based upon the student's academic record. Such documentation shall include but not be limited to the individualized education program, if applicable, report card, or student portfolio.

[**ARC 1331C**, IAB 2/19/14, effective 3/26/14; **ARC 2862C**, IAB 12/7/16, effective 1/11/17]

281—62.9(256,279) Ensuring continuous improvement in reading proficiency.

62.9(1) *Reading proficiency addressed in comprehensive school improvement plan.* To ensure all children are reading proficiently by the end of third grade, each school district shall address reading proficiency as part of its comprehensive school improvement plan, drawing upon information about students from assessments and reassessment conducted pursuant to this chapter and the prevalence of areas in which students are persistently at risk in reading, identified by classroom, elementary school, and other student characteristics.

62.9(2) *Review of chronic early absenteeism.* As part of its comprehensive school improvement plan, each school district shall review chronic early elementary absenteeism for its impact on literacy development.

62.9(3) *Attendance centers with lower levels of reading proficiency.* If more than 15 percent of an attendance center's students are not reading proficiently by the end of third grade, the comprehensive school improvement plan shall include strategies to reduce that percentage, including school and community strategies to raise the percentage of students who are reading at grade level. Strategies adopted under this subrule shall meet the requirements of this chapter.

62.9(4) *Professional development.* Each school district, subject to an appropriation of funds by the general assembly, shall provide professional development services to enhance the skills of elementary teachers in responding to children's unique reading issues and needs and to increase the use of evidence-based strategies.

62.9(5) *Relationship between this chapter and the department's general accreditation standards.* In addition to the requirement in subrule 62.9(1), the department shall consider compliance with and performance under this chapter in its enforcement of the general accreditation standards and school improvement process described in 281—Chapter 12.

[**ARC 1331C**, IAB 2/19/14, effective 3/26/14; **ARC 2862C**, IAB 12/7/16, effective 1/11/17]

281—62.10(256,279) Miscellaneous provisions.

62.10(1) *Services beyond third grade.* Students who are identified as persistently at risk in reading at the end of third grade remain entitled to intensive reading instruction. Nothing in this chapter shall be construed to prevent a school district from offering scientific research-based instruction in reading to students above third grade. Nothing in this chapter shall be construed to prohibit a school district from determining a student above third grade is persistently at risk in reading or from providing services to a student so identified.

62.10(2) *Database.* In implementing subrule 62.6(5), the department may require school districts to enter assessment and progress monitoring data into a statewide database.

62.10(3) *Accredited nonpublic schools.* Nothing in this chapter shall be construed to prevent an accredited nonpublic school from voluntarily complying with this chapter. Nothing in this chapter shall be construed to prevent the department from offering universal screening or progress monitoring instruments to accredited nonpublic school students or to prevent the department from allowing inclusion of those students' data in the database described in subrule 62.10(2).

62.10(4) *Rule of construction.* Nothing in this chapter shall be construed to require a school district to select a particular assessment, instrument, tool, curriculum, or program, so long as the assessment, instrument, tool, curriculum, or program used meets the requirements of this chapter.

[**ARC 1331C**, IAB 2/19/14, effective 3/26/14; **ARC 2862C**, IAB 12/7/16, effective 1/11/17]

These rules are intended to implement Iowa Code section 256.7(31) as amended by 2016 Iowa Acts, chapter 1123, and section 279.68 as amended by 2014 Iowa Acts, chapter 1077, and 2016 Iowa Acts, chapter 1123.

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

[Prior to 7/1/83, Social Services[770] Ch 78]
[Prior to 2/11/87, Human Services[498]]

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

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

78.1(1) Payment will not be made for:

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

b. 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 1 [MPS-1]), adrenoleukodystrophy, metachromatic leukodystrophy, refractory anemia, agnogenic myeloid metaplasia (myelofibrosis), familial erythrophagocytic lymphohistiocytosis and other histiocytic disorders, acute myelofibrosis, Diamond-Blackfan anemia, epidermolysis bullosa, or the following types of leukemia: acute myelocytic leukemia, chronic myelogenous leukemia, juvenile myelomonocytic leukemia, chronic myelomonocytic leukemia, acute myelogenous leukemia, and acute lymphocytic leukemia.

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

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

Liver transplants require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1)*"f"*)

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

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

Heart transplants, heart-lung transplants, artificial hearts, and ventricular assist devices described above require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1)*"f"*) Covered heart transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

(6) Lung transplants. Lung transplants for persons having end-stage pulmonary disease. Lung transplants require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1)*"f"*) Covered transplants are payable only when performed in a facility that meets the requirements of 78.3(10). Heart-lung transplants are covered consistent with criteria in subparagraph (5) above.

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

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

- A history of frequent, acute, and severe metabolic complications (e.g., hypoglycemia, hyperglycemia, or ketoacidosis) requiring medical attention.
- Clinical problems with exogenous insulin therapy that are so severe as to be incapacitating.
- Consistent failure of insulin-based management to prevent acute complications.

The pancreas transplants listed under this subparagraph require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1)*"f"*)

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

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

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

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

d. Payment will not be made for any transplant not specifically listed in paragraph *"a."*

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

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

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

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

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

78.1(24) Topical fluoride varnish. Payment shall be made for application of an FDA-approved topical fluoride varnish, as defined by the current version of the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association, for the purpose of preventing the worsening of early childhood caries in children aged 0 to 36 months of age, when rendered by physicians or other appropriately licensed practitioners under the supervision of or in collaboration with a physician and who are acting within the scope of their practice, licensure, and other applicable state law, subject to the following provisions and limitations:

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

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

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

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

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

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

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

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

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

78.2(5) *Nonprescription drugs.*

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.

[**ARC 8097B**, IAB 9/9/09, effective 11/1/09; **ARC 9175B**, IAB 11/3/10, effective 1/1/11; **ARC 9699B**, IAB 9/7/11, effective 9/1/11; **ARC 9834B**, IAB 11/2/11, effective 11/1/11; **ARC 9882B**, IAB 11/30/11, effective 1/4/12; **ARC 9981B**, IAB 2/8/12, effective 3/14/12; **ARC 0305C**, IAB 9/5/12, effective 11/1/12; **ARC 0580C**, IAB 2/6/13, effective 4/1/13; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

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—subparagraph 81.6(16)*"f"*(3) plus the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(3), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective (a) as of the date of notice by the IME medical services unit that the lower level of care is required or (b) for the days the IME medical services unit determines in an outlier review that the lower level of care was required.

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

78.3(15) Payment for inpatient hospital charges associated with surgical procedures normally done and billed on an outpatient hospital basis is subject to review by the IME medical services acute retrospective review team. Such reviews are based on random claim samples that are pulled on a monthly basis. If the information on a given inpatient claim included in that sample does not appear to support the appropriateness of inpatient level of care, that claim is sent to the IME medical director for further review. If the medical director approves the inpatient level of care, the claim is paid. However, if the medical director determines that the care provided could have been rendered at a lower level of care, the hospital and attending physician are notified accordingly. If the hospital agrees with the finding that a lower level of care was appropriate, the hospital submits a new claim for the lower level of care. If the hospital disagrees with the lower level of care finding, the hospital can submit additional documentation for further review. The hospital or attending physician or both may appeal any final determination by the IME.

78.3(16) Skilled nursing care in "swing beds."

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

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

(1) The hospital has fewer than 100 beds, excluding beds for newborns and intensive care.

(2) The hospital has an existing certification for a swing-bed program, pursuant to paragraph 78.3(16)*"a."*

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

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

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

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

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

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

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

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

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

78.3(18) Preprocedure review by the IME medical services unit is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Preprocedure review is also required for other types of major surgical procedures, such as organ transplants. Criteria are available from the IME medical services unit. (Cross reference 78.28(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.

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

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

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

a. Durable plantar foot orthotic.

b. Plaster impressions for foot orthotic.

c. Molded digital orthotic.

d. Shoe padding when appliances are not practical.

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

f. Rams horn (hypertrophic) nails.

g. Onychomycosis (mycotic) nails.

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

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

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

Reasonable and necessary diagnosis of symptomatic conditions that result from or are associated with partial displacement of foot structures is a covered service. Surgical correction in the subluxated foot structure that is an integral part of the treatment of a foot injury or is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition is a covered service.

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

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

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

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

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

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

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

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

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

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

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

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

(2) Gonioscopy.

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

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

(5) External photography.

(6) Fundus photography.

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

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

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

1. Ordering of corrective lenses.

2. Verification of lenses after fabrication.
3. Adjustment and alignment of completed lens order.

(2) New spectacle lenses are subject to the following limitations:

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

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

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

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

f. Frame service.

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

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

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

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

(3) Safety frames are allowed for:

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

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

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

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

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

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

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

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

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

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

a. Corrected curve lenses, unless clinically contraindicated.

b. Standard plastic, plastic and metal combination, or metal frames.

c. Prescription standards according to the American National Standards Institute (ANSI) standards and tolerance.

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

a. Materials payable by fee schedule are:

(1) Spectacle lenses, single vision and multifocal.

(2) Frames.

(3) Case for glasses.

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

(1) Contact lenses.

(2) Schroeder shield.

(3) Ptosis crutch.

(4) Safety frames.

(5) Subnormal visual aids.

(6) Photochromatic lenses.

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

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

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

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

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

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

(Cross reference 78.28(3))

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

a. Glasses with cosmetic gradient tint lenses or other eyewear for cosmetic purposes.

b. Glasses for occupational eye safety.

c. A second pair of glasses or spare glasses.

d. Cosmetic surgery and experimental medical and surgical procedures.

e. Sunglasses.

f. Progressive bifocal or trifocal lenses.

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

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

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

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

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

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

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

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

78.8(2) *Indications and limitations of coverage.*

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

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
G44.1	Vascular headache NEC*	G54.0-G54.4	Nerve root and plexus disorders, brachial plexus disorders, lumbosacral plexus disorders, cervical root disorders NEC, thoracic root disorders NEC, lumbosacral root disorders NEC	M48.30-M48.33	Traumatic spondylopathy, site unspecified, occipito-atlanto-axial region, cervical region, cervicothoracic region
G44.209	Tension headache, unspecified, not intractable	G54.8	Other nerve root and plexus disorders	M48.35-M48.38	Traumatic spondylopathy, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region
M47.21-M47.28	Other spondylosis with radiculopathy, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	G54.9	Nerve root and plexus disorder, unspecified	M50.20-M50.23	Other cervical disc displacement
M47.811-M47.818	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	G55	Nerve root and plexus compressions in diseases classified elsewhere	M50.30-M50.33	Other cervical disc degeneration
M47.891-M47.898	Other spondylosis, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	M43.00-M43.28	Spondylolysis; spondylolisthesis; fusion of spine	M51.24-M51.27	Other thoracic, thoracolumbar and lumbosacral intervertebral disc displacement
M54.2	Cervicalgia	M43.6	Torticollis	M51.34-M51.37	Other thoracic, thoracolumbar and lumbosacral intervertebral disc degeneration

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
M54.5	Low back pain	M46.00-M46.09	Spinal enthesopathy	M54.30-M54.32	Sciatica
M54.6	Pain in the thoracic spine	M46.41-M46.47	Discitis, unspecified, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region	M54.40-M54.42	Lumbago with sciatica
M54.81	Occipital neuralgia	M48.00-M48.08	Spinal stenosis	M96.1	Postlaminectomy syndrome, NEC
M54.89	Other dorsalgia	M48.34	Traumatic spondylopathy, thoracic region		
M54.9	Dorsalgia, unspecified	M50.10-M50.13	Cervical disc disorder with radiculopathy		
R51	Headache	M50.80-M50.83	Other cervical disc disorders		
		M50.90-M50.93	Cervical disc disorder, unspecified		
		M51.14-M51.17	Intervertebral disc disorders with radiculopathy, thoracic region, thoracolumbar region, lumbar region, lumbosacral region		
		M51.84-M51.87	Other thoracic, thoracolumbar and lumbosacral intervertebral disc disorders		
		M53.0	Cervicocranial syndrome		
		M53.1	Cervicobrachial syndrome		
		M53.2X1-M53.2X9	Spinal instabilities		
		M53.3	Sacrococcygeal disorders NEC		
		M53.80	Other specified dorsopathies, site unspecified		
		M53.84-M53.88	Other specified dorsopathies, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region		
		M53.9	Dorsopathy, unspecified		
		M54.10-M54.18	Radiculopathy		
		M60.80	Other myositis, unspecified site		
		M60.811, M60.812	Other myositis, shoulder, right, left		
		M60.819	Other myositis, unspecified shoulder		
		M60.821, M60.822	Other myositis, upper arm, right, left		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
		M60.829	Other myositis, unspecified upper arm		
		M60.831, M60.832	Other myositis, forearm, right, left		
		M60.839	Other myositis, unspecified forearm		
		M60.841, M60.842	Other myositis, hand, right, left		
		M60.849	Other myositis, unspecified hand		
		M60.851, M60.852	Other myositis, thigh, right, left		
		M60.859	Other myositis, unspecified thigh		
		M60.861, M60.862	Other myositis, lower leg, right, left		
		M60.869	Other myositis, unspecified lower leg		
		M60.871, M60.872	Other myositis, ankle and foot, right, left		
		M60.879	Other myositis, unspecified ankle and foot		
		M60.88, M60.89	Other myositis, other site, multiple sites		
		M60.9	Myositis, unspecified		
		M62.830	Muscle spasm of back		
		M72.9	Fibroblastic disorder, unspecified		
		M79.1	Myalgia		
		M79.2	Neuralgia and neuritis, unspecified		
		M79.7	Fibromyalgia		
		M99.20-M99.23	Subluxation stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.30-M99.33	Osseous stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.40-M99.43	Connective tissue stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.50-M99.53	Intervertebral disc stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.60-M99.63	Osseous and subluxation stenosis of intervertebral foramina, head region, cervical region, thoracic region, lumbar region		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
		M99.70-M99.73	Connective tissue and disc stenosis of intervertebral foramina, head region, cervical region, thoracic region, lumbar region		
		Q76.2	Congenital spondylolisthesis		
		S13.4XXA, S13.4XXD	Sprain of ligaments of cervical spine, initial encounter, subsequent encounter		
		S13.8XXA, S13.8XXD	Sprain of joints and ligaments of other parts of neck, initial encounter, subsequent encounter		
		S16.1XXA, S16.1XXD	Strain of muscle, fascia and tendon at neck level, initial encounter, subsequent encounter		
		S23.3XXA, S23.3XXD	Sprain of ligaments of thoracic spine, initial encounter, subsequent encounter		
		S23.8XXA, S23.8XXD	Sprain of other specified parts of thorax, initial encounter, subsequent encounter		
		S33.5XXA, S33.5XXD	Sprain of ligaments of lumbar spine, initial encounter, subsequent encounter		
		S33.6XXA, S33.6XXD	Sprain of sacroiliac joint, initial encounter, subsequent encounter		

* NEC means not elsewhere classified.

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

c. CMT is not a covered benefit when:

(1) The maximum therapeutic benefit has been achieved for a given condition.

(2) There is not a reasonable expectation that the continuation of CMT would result in improvement of the patient's condition.

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

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

a. The documenting X-ray must be taken at a time reasonably proximate to the initiation of CMT. An X-ray is considered to be reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of CMT. X-rays need not be repeated unless there is a new condition

and no payment shall be made for subsequent X-rays, absent a new condition, consistent with paragraph *"c"* of this subrule. No X-ray is required for pregnant women and for children aged 18 and under.

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

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

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

[**ARC 2164C**, IAB 9/30/15, effective 10/1/15]

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

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

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

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

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

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

Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed $15 per month. Dressings, durable medical equipment, and other supplies shall be obtained from a durable medical equipment dealer or pharmacy. Payment of supplies may be made to home health agencies when a durable medical equipment dealer or pharmacy is not available in the member's community.

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

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

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

counseling; frequency of services; progress of member in response to treatment; and estimated length of time these services will be needed.

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

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

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

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

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

78.9(3) *Skilled nursing services.* Skilled nursing services are services that when performed by a home health agency require a licensed registered nurse or licensed practical nurse to perform. Situations when a service can be safely performed by the member or other nonskilled person who has received the proper training or instruction or when there is no one else to perform the service are not considered a "skilled nursing service." Skilled nursing services shall be available only on an intermittent basis. Intermittent services for skilled nursing services shall be defined as a medically predictable recurring need requiring a skilled nursing service at least once every 60 days, not to exceed five days per week (except as provided below), with an attempt to have a predictable end. Daily visits (six or seven days per week) that are reasonable and necessary and show an attempt to have a predictable end shall be covered for up to three weeks. Coverage of additional daily visits beyond the initial anticipated time frame may be appropriate for a short period of time, based on the medical necessity of service. Medical documentation shall be submitted justifying the need for continued visits, including the physician's estimate of the length of time that additional visits will be necessary. Daily skilled nursing visits or multiple daily visits for wound care or insulin injections shall be covered when ordered by a physician and included in the plan of

care. Other daily skilled nursing visits which are ordered for an indefinite period of time and designated as daily skilled nursing care do not meet the intermittent definition and shall be denied.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Certain household services may be performed by the aide in order to prevent or postpone the member's institutionalization when the primary need of the member for home health aide services

furnished is for personal care. If household services are incidental and do not substantially increase the time spent by the aide in the home, the entire visit is considered a covered service. Domestic or housekeeping services which are not related to patient care are not a covered service if personal care is not rendered during the visit.

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

78.9(8) *Medical social services.*

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

(1) Are reasonable and necessary to the treatment of a member's illness or injury.

(2) Contribute meaningfully to the treatment of the member's condition.

(3) Are under the direction of a physician.

(4) Are provided by or under the supervision of a qualified medical or psychiatric social worker.

(5) Address social problems that are impeding the member's recovery.

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

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

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

(1) The potential risk factors,

(2) The medical factor or symptom which verifies the child is at risk,

(3) The reason the member is unable to obtain care outside of the home,

(4) The medically related task of the home health agency,

(5) The member's diagnosis,

(6) Specific services and goals, and

(7) The medical necessity for the services to be rendered. A single high-risk factor does not provide sufficient documentation of the need for services.

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

(1) Aged 16 or under.

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

(3) Previous history of prenatal complications such as fetal death, eclampsia, C-section delivery, psychosis, or diabetes.

(4) Current prenatal problems such as hypertensive disorders of pregnancy, diabetes, cardiac disease, sickle cell anemia, low hemoglobin, mental illness, or drug or alcohol abuse.

(5) Sociocultural or ethnic problems such as language barriers, lack of family support, insufficient dietary practices, history of child abuse or neglect, or single mother.

(6) Preexisting disabilities such as sensory deficits, or mental or physical disabilities.

(7) Second pregnancy in 12 months.

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

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

(1) Aged 16 or under.

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

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

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

(5) Drug or alcohol abuse.

(6) Symptoms of postpartum psychosis.

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

(8) Demonstrated disturbance in maternal and infant bonding.

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

(10) Insufficient antepartum care by history.

(11) Multiple births.

(12) Nonhospital delivery.

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

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

(2) History of severe respiratory distress.

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

(4) Disabling birth injuries.

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

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

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

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

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

(10) Nutrition or feeding problems.

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

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

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

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

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

(5) Malignancies such as leukemia or carcinoma.

(6) Severe injuries necessitating treatment or rehabilitation.

(7) Disruption in family or peer relationships.

(8) Suspected developmental delay.

(9) Nutritional deficiencies.

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

a. Definitions.

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

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

Private duty nursing or personal care services do not include:

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

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

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

b. Requirements.

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

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

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

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

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

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

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

[**ARC 7548B**, IAB 2/11/09, effective 4/1/09; **ARC 9315B**, IAB 12/29/10, effective 2/2/11; **ARC 0065C**, IAB 4/4/12, effective 6/1/12]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EXCEPTIONS:

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

1. A Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile is completed by a physician, physician assistant, or advanced registered nurse practitioner and qualifies the member in accordance with Medicare criteria.
2. Additional documentation shows that the member requires oxygen for 12 hours or more per day for at least 30 days.
3. Oxygen logs must be maintained by the provider. The time between any reading shall not exceed more than 45 days. The documentation maintained in the provider record must contain the following:
   - The initial, periodic and ending reading on the time meter clock on each oxygen system, and
   - The dates of each initial, periodic and ending reading, and
   - Evidence of ongoing need for oxygen services.
4. The maximum Medicaid payment shall be based on the least costly method of oxygen delivery.
5. Oxygen prescribed "PRN" or "as necessary" is not payable.
6. Medicaid payment shall be made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system and costs for servicing and repair of equipment are included in the Medicaid payment and shall not be separately payable.
7. Payment is not allowed for oxygen services that are not documented according to the department of inspections and appeals requirements at 481—subrule 58.21(8).

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

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

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

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

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

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

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

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

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

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

Decubitus equipment.

Dialysis equipment.

Diaphragm (contraceptive device).

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

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

Heat/cold application device.

Hospital bed and accessories.

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

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

Lymphedema pump.

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

Neuromuscular stimulator.

Oximeter.

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

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

Phototherapy bilirubin light.

Protective helmet.

Seat lift chair.

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

Traction equipment.

Ventilator.

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

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

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

(3) A second oxygen system is not covered by Medicaid when used as a backup for oxygen concentrators or as a standby in case of emergency. Members may be provided with a portable oxygen system to complement a stationary oxygen system, or to be used by itself, with documentation from the physician, physician assistant, or advanced registered nurse practitioner of the specific activities for which portable oxygen is medically necessary.

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

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

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

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

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

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

(1) Artificial eyes.

(2) Artificial limbs.

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

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

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

(6) Ostomy appliances.

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

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

(9) Tracheotomy tubes.

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

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

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

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

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

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

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

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

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

Catheter (indwelling Foley).

Colostomy and ileostomy appliances.

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

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

Dialysis supplies.

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

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

Dressings.

Elastic antiembolism support stocking.

Enema.

Hearing aid batteries.

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

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

Ostomy appliances and supplies.

Respirator supplies.

Shoes, diabetic.

Surgical supplies.

Urinary collection supplies.

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

Catheter (indwelling Foley).

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

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

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

Ostomy appliances and supplies.

Shoes, diabetic.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Needs upper body support while sitting, and

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

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

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

m. Oral nutritional products. Payment shall be approved when the member is not able to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology, to the extent that supplementation is necessary to provide 51 percent or more of the daily caloric intake, or when the use of oral nutritional products is otherwise determined medically necessary in accordance with evidence-based guidelines for treatment of the member's condition. Nutritional products consumed orally are not covered for members in nursing facilities or intermediate care facilities for persons with an intellectual disability.

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

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

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

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

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

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

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

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

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

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

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

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

One patient - normal allowance

Two patients - 3/4 normal allowance per patient

Three patients - 2/3 normal allowance per patient

Four patients - 5/8 normal allowance per patient

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

78.11(5) In the event that more than one ambulance service is called to provide ground ambulance transport, payment shall be made only to one ambulance company. When a paramedic from one ambulance service joins a ground ambulance company already in transport, coverage is not available for the services and supplies provided by the paramedic.

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

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

78.12(1) *Definitions.*

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

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

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

b. Reimbursement for costs of the member's meals necessary during periods of transportation and medical treatment.

c. Reimbursement of lodging expenses incurred by the member during periods of transportation and medical treatment.

d. Reimbursement of car rental costs incurred by the member during periods of transportation and medical treatment.

e. Reimbursement of a medically necessary escort's travel expenses when an escort is required because of the member's needs.

78.13(2) *Exclusions.* Nonemergency medical transportation is not available through the Iowa Medicaid program for:

a. Transportation to obtain services not covered by Iowa Medicaid;

b. Transportation to providers that are not enrolled in Iowa Medicaid;

c. Transportation for members residing in nursing facilities or ICF/ID facilities when such facilities provide the transportation (i.e., within 30 miles, one way, of the facility);

d. Transportation of family members to visit or participate in therapy when the member is hospitalized or institutionalized;

e. Transportation to durable medical equipment providers when such providers offer a delivery service that can be accessed at no cost to the member, unless the equipment requires a fitting that cannot be provided without transporting the member;

f. Reimbursement to HCBS and Medicaid providers for transportation provided as part of other covered services, such as personal care, home health, and supported community living services;

g. Transportation to a pharmacy that provides a free delivery service, with the exception of new prescription fills that are otherwise not available to the patient in the absence of nonemergency medical transportation services; and

h. Emergency transportation.

78.13(3) *Conditions and limitations on covered services.* Nonemergency medical transportation services are subject to the following limitations and conditions:

a. Member request. When a member needs nonemergency transportation to receive medical care provided by the Iowa Medicaid program, the member must contact the broker with as much advance notice as possible, but not more than 30 days' advance notice.

(1) Generally, members who require a ride from a transportation provider scheduled by the broker must contact the broker at least two business days in advance of the member's appointment to schedule the transportation. For purposes of calculating the two-business-day notice obligation, the advance notice includes the day of the medical appointment but not the day of the telephone call.

(2) If the member's nonemergency transportation need for a ride from a transportation provider scheduled by the broker makes the provision of two business days' notice impossible because of the member's urgent transportation need, the member must provide as much advance notice as is possible before the transportation need so that the broker can appropriately schedule the most economical form of transportation for the member. Urgent transportation needs for a ride from a transportation provider scheduled by the broker are limited to unscheduled episodic situations in which there is no immediate threat to life or limb but which require that the broker schedule transportation with less than two business days' notice. Examples of urgent trips include, but are not limited to:

1. Postsurgical or medical follow-up care specified by a health care provider;
2. Unexpected preoperative appointments;
3. Hospital discharges;
4. Appointments for new medical conditions or tests; and
5. Dialysis.

(3) The two-business-day advance notice obligation does not apply when the member requests only mileage reimbursement. To be eligible for mileage reimbursement:

1. The member must notify the broker no later than the day of the trip;
2. The transportation must be provided by a driver with a valid driver's license and insurance coverage on the vehicle at the time of the transport; and
3. The other requirements of rule 441—78.13(249A) must be met.

b. No free transportation alternatives available. Member transportation through the nonemergency medical transportation broker is not available to the member when the member is capable of securing the member's own transportation at no cost to the member (e.g., free-gas voucher programs).

c. No member transportation alternatives available. Members who have their own transportation available to them are required to use their own vehicle and seek mileage reimbursement. For purposes of determining whether or not the member has the member's own transportation that is available to the member, the broker shall take into consideration:

(1) Whether the member owns a vehicle;

(2) Whether a member-owned vehicle is in working mechanical order and is licensed;

(3) Whether the member has a valid driver's license and auto insurance;

(4) Whether the member is unable to drive because of age, physical condition, cognitive impairment, or developmental limitations; and

(5) Whether friends or family are available to transport the member to the member's medical appointment and receive mileage reimbursement.

d. Limitations on reimbursement for meals. Reimbursement for costs of members' meals necessary during periods of transportation and medical treatment is limited to situations in which:

(1) The transportation being provided spans the entire meal period;

(2) The one-way distance to or from the medical appointment is more than 50 miles;

(3) The meal is necessary to satisfy the needs of the member or medically necessary escort; and

(4) The meal reimbursement is limited to the subsistence allowance amounts applicable to state officers and state employees pursuant to Iowa Administrative Code rule 11—41.6(8A) and is supported by detailed receipts.

e. Limitations on reimbursement for lodging expenses. Reimbursement of lodging expenses incurred by members during periods of transportation and medical treatment is limited to reasonable reimbursement for expenses incurred by the member or the medically necessary escort, or both, during a nonemergency trip provided by the broker when the one-way distance to or from the medical appointment is more than 50 miles, supported by detailed receipts, and required for treatment.

f. Closest medical provider. Nonemergency medical transportation will only be provided to members to the closest qualified and enrolled Medicaid provider unless:

(1) The difference between the closest qualified and enrolled Medicaid provider and the enrolled provider requested by the member is less than 10 miles one way; or

(2) The additional cost of transportation to the enrolled provider requested by the member is medically justified based on:

1. The member's previous relationship with the requested provider; or
2. The member's prior experience with the requested provider; or
3. The requested provider's special expertise or experience; or
4. A referral requiring the member to be seen by the requested provider.

g. Member scheduling obligations. Members who require a ride will need to schedule medical appointments on days the transportation provider sends a shuttle to facilitate the provision of the most economical nonemergency medical transportation available, subject to reasonable medical exceptions.

h. Abusive behavior. Members who are abusive or inappropriate may be restricted by the department to only receiving mileage reimbursement. Such restricted members will be responsible for finding their own way to their medical appointments.

i. Member claim submission. Members must submit claims and supporting documentation to the broker within 120 days of the date of service. The broker shall deny member claims submitted more than 120 days from the date of service.

78.13(4) *Grievance procedure.* The broker shall establish an internal grievance procedure for members and transportation providers.

a. Members may appeal to the department pursuant to 441—Chapter 7 as an "aggrieved person."

b. Transportation providers.

(1) Consent for state fair hearing.

1. Transportation providers that are contracted with the broker and are in good standing with the broker may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member.

2. The transportation provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member's lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the transportation provider submits a document providing such member approval with the request for a state fair hearing.

3. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider's bringing the state fair hearing on the member's behalf.

(2) For all transportation provider grievances not addressed by paragraph 78.13(4)*"b,"* the grievance process shall end with binding arbitration, with a designee of the Iowa Medicaid enterprise as arbitrator.

[**ARC 8344B**, IAB 12/2/09, effective 12/1/09; **ARC 8643B**, IAB 4/7/10, effective 3/11/10; **ARC 8994B**, IAB 8/11/10, effective 10/1/10; **ARC 1264C**, IAB 1/8/14, effective 3/1/14; **ARC 1976C**, IAB 4/29/15, effective 7/1/15]

441—78.14(249A) Hearing aids. Payment shall be approved for a hearing aid and examinations subject to the following conditions:

78.14(1) *Physician examination.* The member shall have an examination by a physician to determine that the member has no condition which would contraindicate the use of a hearing aid. This report shall be documented in the patient record. The requirement for a physician evaluation shall be waived for members 18 years of age or older when the member has signed an informed consent statement acknowledging that the member:

a. Has been advised that it may be in the member's best health interest to receive a medical evaluation from a licensed physician before purchase of a hearing aid.

b. Does not wish to receive a medical evaluation prior to purchase of a hearing aid.

78.14(2) *Audiological testings.* A physician or an audiologist shall perform audiological testing as a part of making a determination that a member could benefit from the use of a hearing aid. The department shall cover vestibular testing performed by an audiologist only when prescribed by a physician.

78.14(3) *Hearing aid evaluation.* A physician or an audiologist shall perform a hearing aid evaluation to establish if a member could benefit from a hearing aid. When a hearing aid is recommended for a member, the physician or audiologist recommending the hearing aid shall see the member at least one time within 30 days after purchase of the hearing aid to determine that the aid is adequate.

78.14(4) *Hearing aid selection.* A physician or audiologist may recommend a specific brand or model appropriate to the member's condition. When a physician or an audiologist makes a general hearing aid recommendation, a hearing aid dispenser may perform the tests to determine the specific brand or model appropriate to the member's condition.

78.14(5) *Travel.* When a member is unable to travel to the physician or audiologist because of health reasons, the department shall make payment for travel to the member's place of residence or other suitable location. The department shall make payment to physicians as specified in 78.1(8) and payment to audiologists at the same rate it reimburses state employees for travel.

78.14(6) *Purchase of hearing aid.* The department shall pay for the type of hearing aid recommended when purchased from an eligible licensed hearing aid dispenser pursuant to rule 441—77.13(249A). The department shall pay for binaural amplification when:

a. A child needs the aid for speech development,

b. The aid is needed for educational or vocational purposes,

c. The aid is for a blind member,

d. The member's hearing loss has caused marked restriction of daily activities and constriction of interests resulting in seriously impaired ability to relate to other people, or

e. Lack of binaural amplification poses a hazard to a member's safety.

78.14(7) *Payment for hearing aids.*

a. Payment for hearing aids shall be acquisition cost plus a dispensing fee covering the fitting and service for six months. The department shall make payment for routine service after the first six months. Dispensing fees and payment for routine service shall not exceed the fee schedule appropriate to the place of service. Shipping and handling charges are not allowed.

b. Payment for ear mold and batteries shall be at the current audiologist's fee schedule.

c. Payment for repairs shall be made to the dealer for repairs made by the dealer. Payment for in-house repairs shall be made at the current fee schedule. Payment shall also be made to the dealer for repairs when the hearing aid is repaired by the manufacturer or manufacturer's depot. Payment for out-of-house repairs shall be at the amount shown on the manufacturer's invoice. Payment shall be allowed for a service or handling charge when it is necessary for repairs to be performed by the manufacturer or manufacturer's depot and this charge is made to the general public.

d. Prior approval. When prior approval is required, Form 470-4767, Examiner Report of Need for a Hearing Aid, shall be submitted along with the forms required by 441—paragraph 79.8(1)*"a."*

(1) Payment for the replacement of a hearing aid less than four years old shall require prior approval except when the member is under 21 years of age. The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the member's hearing that would require a different hearing aid. (Cross reference 78.28(4)*"a"*)

(2) Payment for a hearing aid costing more than $650 shall require prior approval. The department shall approve payment for either of the following purposes (Cross reference 78.28(4)*"b"*):

1. Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

2. Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job, and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

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

[**ARC 8008B**, IAB 7/29/09, effective 8/1/09]

441—78.15(249A) Orthopedic shoes. Payment shall be approved only for depth or custom-molded orthopedic shoes, inserts, and modifications, subject to the following definitions and conditions.

78.15(1) *Definitions.*

"Custom-molded shoe" means a shoe that:

1. Has been constructed over a cast or model of the recipient's foot;
2. Is made of leather or another suitable material of equal quality;
3. Has inserts that can be removed, altered, or replaced according to the recipient's conditions and needs; and
4. Has some form of closure.

"Depth shoe" means a shoe that:

1. Has a full length, heel-to-toe filler that when removed provides a minimum of 3/16 inch of additional depth used to accommodate custom-molded or customized inserts;
2. Is made from leather or another suitable material of equal quality;
3. Has some form of closure; and
4. Is available in full and half sizes with a minimum of three widths, so that the sole is graded to the size and width of the upper portions of the shoe according to the American Standard last sizing schedule or its equivalent.

"Insert" means a foot mold or orthosis constructed of more than one layer of a material that:

1. Is soft enough and firm enough to take and hold an impression during use, and
2. Is molded to the recipient's foot or is made over a model of the foot.

78.15(2) *Prescription.* The recipient shall present to the provider a written prescription by a physician, a podiatrist, a physician assistant, or an advanced registered nurse practitioner that includes all of the following:

1. The date.
2. The patient's diagnosis.
3. The reason orthopedic shoes are needed.
4. The probable duration of need.
5. A specific description of any required modification of the shoes.

78.15(3) *Diagnosis.* The recipient shall have a diagnosis of an orthopedic, neuromuscular, vascular, or insensate foot condition, supported by applicable codes from the current version of the International Classification of Diseases (ICD). A diagnosis of flat feet is not covered.

a. A recipient with diabetes must meet the Medicare criteria for therapeutic depth and custom-molded shoes.

b. Custom-molded shoes are covered only when the recipient has a foot deformity and the provider has documentation of all of the following:

(1) The reasons the recipient cannot be fitted with a depth shoe.
(2) Pain.
(3) Tissue breakdown or a high probability of tissue breakdown.

(4) Any limitation on walking.

78.15(4) *Frequency.* Only two pairs of orthopedic shoes are allowed per recipient in a 12-month period unless documentation of change in size or evidence of excessive wear is submitted. EXCEPTION: School-aged children under the age of 21 may obtain athletic shoes in addition to the two pairs of shoes in a 12-month period.

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

441—78.16(249A) Community mental health centers. Payment will be approved for all reasonable and necessary services provided by a psychiatrist on the staff of a community mental health center. Payment will be approved for services provided by a clinical psychologist, social worker or psychiatric nurse on the staff of the center, subject to the following conditions:

78.16(1) Payment to a community mental health center will be approved for reasonable and necessary services provided to members by a psychiatrist, psychologist, social worker or psychiatric nurse on the staff of the center under the following conditions:

a. Services must be rendered under the supervision of a board-eligible or board-certified psychiatrist. All services must be performed under the supervision of a board-eligible or board-certified psychiatrist subject to the conditions set forth in 78.16(1)*"b"* with the following exceptions:

(1) Services by staff psychiatrists, or

(2) Services rendered by psychologists meeting the requirements of the National Register of Health Service Providers in Psychology, or

(3) Services provided by a staff member listed in this subrule performing the preliminary diagnostic evaluation of a member for voluntary admission to one of the state mental health institutes.

b. Supervisory process.

(1) Each patient shall have an initial evaluation completed which shall include at least one personal evaluation interview with a mental health professional, as defined under Iowa Code section 228.1. If the evaluation interview results indicate a need for an interview with a board-eligible or board-certified psychiatrist, then such referral shall be made. This must be accomplished before submission of the first claim for services rendered to that patient.

(2) Ongoing review and assessment of patients' treatment needs, treatment plans, and the appropriateness of services rendered shall be assured through the peer review process in effect for community mental health centers, as directed by 2002 Iowa Acts, chapter 1120, section 13.

(3) and (4) Rescinded IAB 2/5/03, effective 2/1/03.

78.16(2) The treatment plans for and services rendered to patients of the center shall be evaluated and revised as necessary and appropriate, consistent with the standards of the peer review process described in subparagraph 78.16(1)*"b"*(1).

78.16(3) The peer review process and related activities, as described under subparagraph 78.16(1)*"b"*(1), are not payable as separate services under the Medicaid program. The center shall maintain the results of and information related to the peer review process, and these records shall be subject to audit by the department of human services or department designees, as necessary and appropriate.

78.16(4) Clinical records of medical assistance patients shall be available to the carrier on request. All these records shall be held confidential.

78.16(5) At the time of application for participation in the program the center will be provided with a form on which to list its professional staff. The center shall report acquisitions or losses of professional staff to the carrier within ten days.

78.16(6) Payment to a community mental health center will be approved for day treatment services for persons aged 21 or over if the center is certified by the department for day treatment services, the services are provided on the premises of the community mental health center or satellite office of the community mental health center, and the services meet the standards outlined herein.

a. Community mental health centers providing day treatment services for persons aged 21 or over shall have available a written narrative providing the following day treatment information:

(1) Documented need for day treatment services for persons aged 21 and over in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 21 and over that meet the day treatment program guidelines noted in 78.16(6)*"b."*

(3) Organization and staffing including how the day treatment program for persons aged 21 and over fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Day treatment services for persons aged 21 and over shall be structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression, and preventing hospitalization.

(1) Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions and training in medication management.

(2) Services are structured with an emphasis on program variation according to individual need.

(3) Services are provided for a period of three to five hours per day, three or four times per week.

c. Payment will be approved for day treatment services provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular, and documented. The employee or consultant shall meet the following minimum requirements:

(1) Have a bachelor's degree in a human services related field from an accredited college or university; or

(2) Have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services.

d. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(7).

78.16(7) Payment to a community mental health center will be approved for day treatment services for persons aged 20 or under if the center is certified by the department for day treatment services and the services are provided on the premises of the community mental health center or satellite office of the community mental health center. Exception: Field trips away from the premises are a covered service when the trip is therapeutic and integrated into the day treatment program's description and milieu plan.

Day treatment coverage will be limited to a maximum of 15 hours per week. Day treatment services for persons aged 20 or under shall be outpatient services provided to persons who are not inpatients in a medical institution or residents of a group care facility licensed under 441—Chapter 114.

a. Program documentation. Community mental health centers providing day treatment services for persons aged 20 or under shall have available a written narrative which provides the following day treatment program information:

(1) Documented need for day treatment services for persons aged 20 or under in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 20 or under that meet the guidelines noted in paragraphs *"c"* to *"h"* below.

(3) Organization and staffing including how the day treatment program for persons aged 20 or under fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Program standards. Medicaid day treatment program services for persons aged 20 and under shall meet the following standards:

(1) Staffing shall:

1. Be sufficient to deliver program services and provide stable, consistent, and cohesive milieu with a staff-to-patient ratio of no less than one staff for each eight participants. Clinical, professional, and paraprofessional staff may be counted in determining the staff-to-patient ratio. Professional or clinical staff are those staff who are either mental health professionals as defined in rule 441—33.1(225C,230A) or persons employed for the purpose of providing offered services under the supervision of a mental health professional. All other staff (administrative, adjunctive, support, nonclinical, clerical, and consulting staff or professional clinical staff) when engaged in administrative or clerical activities shall not be counted in determining the staff-to-patient ratio or in defining program staffing patterns. Educational staff may be counted in the staff-to-patient ratio.

2. Reflect how program continuity will be provided.

3. Reflect an interdisciplinary team of professionals and paraprofessionals.

4. Include a designated director who is a mental health professional as defined in rule 441—33.1(225C,230A). The director shall be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness.

5. Be provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives direct professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular and documented. The employee or consultant shall have a bachelor's degree in a human services related field from an accredited college or university or have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services. Exception: Other certified or licensed staff, such as certified addiction counselors or certified occupational and recreational therapy assistants, are eligible to provide direct services under the general supervision of a mental health professional, but they shall not be included in the staff-to-patient ratio.

(2) There shall be written policies and procedures addressing the following: admission criteria; patient assessment; patient evaluation; treatment plan; discharge plan; community linkage with other psychiatric, mental health, and human service providers; a process to review the quality of care being provided with a quarterly review of the effectiveness of the clinical program; postdischarge services; and the scope of services provided.

(3) The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.

(4) The length of stay in a day treatment program for persons aged 20 or under shall not exceed 180 treatment days per episode of care, unless the rationale for a longer stay is documented in the patient's case record and treatment plan every 30 calendar days after the first 180 treatment days.

(5) Programming shall meet the individual needs of the patient. A description of services provided for patients shall be documented along with a schedule of when service activities are available including the days and hours of program availability.

(6) There shall be a written plan for accessing emergency services 24 hours a day, seven days a week.

(7) The program shall maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships shall exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships shall also exist with appropriate school districts and educational cooperatives. Relationships with other entities such as physicians, hospitals, private practitioners, halfway houses, the department, juvenile justice system, community support groups, and child advocacy groups are encouraged. The provider's program description will describe how community links will be established and maintained.

(8) Psychotherapeutic treatment services and psychosocial rehabilitation services shall be available. A description of the services shall accompany the application for certification.

(9) The program shall maintain a distinct clinical record for each patient admitted. Documentation, at a minimum, shall include: the specific services rendered, the date and actual time services were rendered, who rendered the services, the setting in which the services were rendered, the amount of time it took to deliver the services, the relationship of the services to the treatment regimen described in the plan of care, and updates describing the patient's progress.

c. Program services. Day treatment services for persons aged 20 or under shall be a time-limited, goal-oriented active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu. Time-limited means that the patient is not expected to need services indefinitely or lifelong, and that the primary goal of the program is to improve the behavioral functioning or emotional adjustment of the patient in order that the service is no longer necessary. Day treatment services shall be provided within the least restrictive therapeutically appropriate context and shall be community-based and family focused. The overall expected outcome is clinically adaptive behavior on the part of the patient and the family.

At a minimum, day treatment services will be expected to improve the patient's condition, restore the condition to the level of functioning prior to onset of illness, control symptoms, or establish and maintain a functional level to avoid further deterioration or hospitalization. Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to establish, retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

Day treatment programs shall use an integrated, comprehensive and complementary schedule of therapeutic activities and shall have the capacity to treat a wide array of clinical conditions.

The following services shall be available as components of the day treatment program. These services are not separately billable to Medicaid, as day treatment reimbursement includes reimbursement for all day treatment components.

(1) Psychotherapeutic treatment services (examples would include individual, group, and family therapy).

(2) Psychosocial rehabilitation services. Active treatment examples include, but are not limited to, individual and group therapy, medication evaluation and management, expressive therapies, and theme groups such as communication skills, assertiveness training, other forms of community skills training, stress management, chemical dependency counseling, education, and prevention, symptom recognition and reduction, problem solving, relaxation techniques, and victimization (sexual, emotional, or physical abuse issues).

Other program components may be provided, such as personal hygiene, recreation, community awareness, arts and crafts, and social activities designed to improve interpersonal skills and family mental health. Although these other services may be provided, they are not the primary focus of treatment.

(3) Evaluation services to determine need for day treatment prior to program admission. For persons for whom clarification is needed to determine whether day treatment is an appropriate therapy approach, or for persons who do not clearly meet admission criteria, an evaluation service may be performed. Evaluation services shall be individual and family evaluation activities made available to courts, schools, other agencies, and individuals upon request, who assess, plan, and link individuals with appropriate services. This service must be completed by a mental health professional. An evaluation from another source performed within the previous 12 months or sooner if there has not been a change may be substituted. Medicaid will not make separate payment for these services under the day treatment program.

(4) Assessment services. All day treatment patients will receive a formal, comprehensive biopsychosocial assessment of day treatment needs including, if applicable, a diagnostic impression based on the current Diagnostic and Statistical Manual of Mental Disorders. An assessment from another source performed within the previous 12 months may be used if the symptomatology is the same as 12 months ago. If not, parts of the assessment which reflect current functioning may be used as an

update. Using the assessment, a comprehensive summation will be produced, including the findings of all assessments performed. The summary will be used in forming a treatment plan including treatment goals. Indicators for discharge planning, including recommended follow-up goals and provision for future services, should also be considered, and consistently monitored.

(5) The day treatment program may include an educational component as an additional service. The patient's educational needs shall be served without conflict from the day treatment program. Hours in which the patient is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid.

d. Admission criteria. Admission criteria for day treatment services for persons aged 20 or under shall reflect the following clinical indicators:

(1) The patient is at risk for exclusion from normative community activities or residence.

(2) The patient exhibits psychiatric symptoms, disturbances of conduct, decompensating conditions affecting mental health, severe developmental delays, psychological symptoms, or chemical dependency issues sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.

(3) Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate.

(4) The patient's principal caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the patient, to enable adequate control of the patient's behavior, and must be involved in the patient's treatment. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

(5) The patient has the capacity to benefit from the interventions provided.

e. Individual treatment plan. Each patient receiving day treatment services shall have a treatment plan prepared. A preliminary treatment plan should be formulated within 3 days of participation after admission, and replaced within 30 calendar days by a comprehensive, formalized plan utilizing the comprehensive assessment. This individual treatment plan should reflect the patient's strengths and weaknesses and identify areas of therapeutic focus. The treatment goals which are general statements of consumer outcomes shall be related to identified strengths, weaknesses, and clinical needs with time-limited, measurable objectives. Objectives shall be related to the goal and have specific anticipated outcomes. Methods that will be used to pursue the objectives shall be stated. The plan should be reviewed and revised as needed, but shall be reviewed at least every 30 calendar days. The treatment plan shall be developed or approved by a board-eligible or board-certified psychiatrist, a staff psychiatrist, physician, or a psychologist registered either on the "National Register of Health Service Providers in Psychology" or the "Iowa Register of Health Service Providers for Psychology." Approval will be evidenced by a signature of the physician or health service provider.

f. Discharge criteria. Discharge criteria for the day treatment program for persons aged 20 or under shall incorporate at least the following indicators:

(1) In the case of patient improvement:

1. The patient's clinical condition has improved as shown by symptom relief, behavioral control, or indication of mastery of skills at the patient's developmental level. Reduced interference with and increased responsibility with social, vocational, interpersonal, or educational goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.

2. Treatment goals in the individualized treatment plan have been achieved.

3. An aftercare plan has been developed that is appropriate to the patient's needs and agreed to by the patient and family, custodian, or guardian.

(2) If the patient does not improve:

1. The patient's clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.

2. Patient, family, or custodian noncompliance with treatment or with program rules exists.

g. Coordination of services. Programming services shall be provided in accordance with the individual treatment plan developed by appropriate day treatment staff, in collaboration with the patient

and appropriate caretaker figure (parent, guardian, or principal caretaker), and under the supervision of the program director, coordinator, or supervisor.

The program for each patient will be coordinated by primary care staff of the community mental health center. A coordinated, consistent array of scheduled therapeutic services and activities shall comprise the day treatment program. These may include counseling or psychotherapy, theme groups, social skills development, behavior management, and other adjunctive therapies. At least 50 percent of scheduled therapeutic program hours exclusive of educational hours for each patient shall consist of active treatment that specifically addresses the targeted problems of the population served. Active treatment shall be defined as treatment in which the program staff assume significant responsibility and often intervene.

Family, guardian, or principal caretaker shall be involved with the program through family therapy sessions or scheduled family components of the program. They will be encouraged to adopt an active role in treatment. Medicaid will not make separate payment for family therapy services. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

Therapeutic activities will be scheduled according to the needs of the patients, both individually and as a group.

Scheduled therapeutic activities, which may include other program components as described above, shall be provided at least 3 hours per week up to a maximum of 15 hours per week.

h. Stable milieu. The program shall formally seek to provide a stable, consistent, and cohesive therapeutic milieu. In part this will be encouraged by scheduling attendance such that a stable core of patients exists as much as possible. The milieu will consider the developmental and social stage of the participants such that no patient will be significantly involved with other patients who are likely to contribute to retardation or deterioration of the patient's social and emotional functioning. To help establish a sense of program identity, the array of therapeutic interventions shall be specifically identified as the day treatment program. Program planning meetings shall be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider shall state how milieu stability will be provided.

i. Chronic mental illness. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(6).

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

441—78.17(249A) Physical therapists. Payment will be approved for the same services payable under Title XVIII of the Social Security Act (Medicare).

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

441—78.18(249A) Screening centers. Payment will be approved for health screening as defined in 441—subrule 84.1(1) for Medicaid members under 21 years of age.

78.18(1) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a screening center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.18(2) Payment will be approved for necessary laboratory service related to an element of screening when performed by the screening center and billed as a separate item.

78.18(3) Periodicity schedules for health, hearing, vision, and dental screenings.

a. Payment will be approved for health, vision, and hearing screenings as follows:

(1) Six screenings in the first year of life.

(2) Four screenings between the ages of 1 and 2.

(3) One screening a year at ages 3, 4, 5, and 6.

(4) One screening a year at ages 8, 10, 12, 14, 16, 18, and 20.

b. Payment for dental screenings will be approved in conjunction with the health screenings up to age 12 months. Screenings will be approved at ages 12 months and 24 months and thereafter at six-month intervals up to age 21.

c. Interperiodic screenings will be approved as medically necessary.

78.18(4) When it is established by the periodicity schedule in 78.18(3) that an individual is in need of screening the individual will receive a notice that screening is due.

78.18(5) When an individual is screened, a member of the screening center shall complete a medical history. The medical history shall become part of the individual's medical record.

78.18(6) Rescinded IAB 12/3/08, effective 2/1/09.

78.18(7) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a screening center for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.18(8) Payment shall be made for dental services provided by a dental hygienist employed by or under contract with a screening center.

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

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.19(249A) Rehabilitation agencies.

78.19(1) *Coverage of services.*

a. General provisions regarding coverage of services.

(1) Services are provided in the member's home or in a care facility (other than a hospital) by a speech therapist, physical therapist, or occupational therapist employed by or contracted by the agency. Services provided to a member residing in a residential care facility are payable when the facility submits a signed statement that the facility does not have these services available. The statement need only be submitted at the start of care unless the situation changes. Payment will not be made to a rehabilitation agency for therapy provided to a member residing in a nursing facility or an intermediate care facility for persons with an intellectual disability since these facilities are responsible for providing or paying for services required by members.

(2) All services must be determined to be medically necessary, reasonable, and meet a significant need of the recipient that cannot be met by a family member, friend, medical staff personnel, or other caregiver; must meet accepted standards of medical practice; and must be a specific and effective treatment for a patient's medical or disabling condition.

(3) In order for a service to be payable, a licensed therapist must complete a plan of treatment every 30 days and indicate the type of service required. The plan of treatment must contain the information noted in subrule 78.19(2).

(4) There is no specific limitation on the number of visits for which payment through the program will be made so long as that amount of service is medically necessary in the individual case, is related to a diagnosed medical impairment or disabling condition, and meets the current standards of practice in each related field. Documentation must be submitted with each claim to support the need for the number of services being provided.

(5) Payments will be made both for restorative service and also for maintenance types of service. Essentially, maintenance services means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This would include persons with long-term illnesses or a disabling condition whose status is stable rather than posthospital. Refer to 78.19(1)*"b"*(7) and (8) for guidelines under restorative and maintenance therapy.

(6) Restorative or maintenance therapy sessions must meet the following criteria:

1. There must be face-to-face patient contact interaction.

2. Services must be provided primarily on an individual basis. Group therapy is covered, but total units of service in a month shall not exceed total units of individual therapy. Family members receiving therapy may be included as part of a group.

3. Treatment sessions may be no less than 15 minutes of service and no more than 60 minutes of service per date unless more than 60 minutes of service is required for a treatment session due to the patient's specific condition. If more than 60 minutes of service is required for a treatment session, additional documentation of the specific condition and the need for the longer treatment session shall be submitted with the claim. A unit of treatment shall be considered to be 15 minutes in length.

4. Progress must be documented in measurable statistics in the progress notes in order for services to be reimbursed. Refer to 78.19(1)*"b"*(7) and (8) for guidelines under restorative and maintenance therapy.

(7) Payment will be made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a patient's rehabilitation potential and establish appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic or trial therapy. Refer to 78.19(1)*"b"*(16) for guidelines under diagnostic or trial therapy.

b. Physical therapy services.

(1) To be covered under rehabilitation agency services, physical therapy services must relate directly and specifically to an active written treatment plan, follow a treatment plan established by the licensed therapist after consultation with the physician, be reasonable and necessary to the treatment of the person's illness, injury, or disabling condition, be specific and effective treatment for the patient's medical or disabling condition, and be of such a level of complexity and sophistication, or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

(2) A qualified physical therapist assistant may provide any restorative services performed by a licensed physical therapist under supervision of the therapist as set forth in the department of public health, professional licensure division, 645—subrule 200.20(7).

(3) The initial physical therapy evaluation must be provided by a licensed physical therapist.

(4) There must be an expectation that there will be a significant, practical improvement in the patient's condition in a reasonable amount of time based on the patient's restorative potential assessed by the physician.

(5) It must be demonstrated there is a need to establish a safe and effective maintenance program related to a specific disease state, illness, injury, or disabling condition.

(6) The amount, frequency, and duration of the services must be reasonable.

(7) Restorative therapy must be reasonable and necessary to the treatment of the patient's injury or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment. There must be an expectation that the patient's medical or disabling condition will show functional improvement in a reasonable period of time. Functional improvement means that demonstrable measurable increases have occurred in the patient's level of independence outside the therapeutic environment.

(8) Generally, maintenance therapy means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes persons with long-term illnesses or disabling conditions whose status is stable rather than posthospital. Maintenance therapy is also appropriate for individuals whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels.

Where a maintenance program is appropriate, the initial evaluation and the instruction of the patient, family members, home health aides, facility personnel, or other caregivers to carry out the program are considered a covered physical therapy service. Payment shall be made for a maximum of three visits to establish a maintenance program and instruct the caregivers. Payment for supervisory visits to monitor the program is limited to two per month for a maximum period of 12 months. The plan of treatment must specify the anticipated monitoring activity of the supervisor.

Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

After 12 months of maintenance therapy, a reevaluation is a covered service, if medically necessary. A reevaluation will be considered medically necessary only if there is a significant change in residential or employment situation or the patient exhibits an increase or decrease in functional ability or motivation,

clearing of confusion, or the remission of some other medical condition which previously contraindicated restorative therapy. A statement by the interdisciplinary team of a person with developmental disabilities recommending a reevaluation and stating the basis for medical necessity will be considered as supporting the necessity of a reevaluation and may expedite approval.

(Restorative and maintenance therapy definitions also apply to speech and occupational therapy.)

When a patient is under a restorative physical therapy program, the patient's condition is regularly reevaluated and the program adjusted by the physical therapist. It is expected that prior to discharge, a maintenance program has been designed by the physical therapist. Consequently, where a maintenance program is not established until after the restorative program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage.

(9) Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. These are covered when the patient's condition is complicated by other conditions such as a circulatory deficiency or open wounds or if the service is an integral part of a skilled physical therapy procedure.

(10) Gait training and gait evaluation and training constitute a covered service if the patient's ability to walk has been impaired by a neurological, muscular or skeletal condition or illness. The gait training must be expected to significantly improve the patient's ability to walk or level of independence.

Repetitious exercise to increase endurance of weak or unstable patients can be safely provided by supportive personnel, e.g., aides, nursing personnel. Therefore, it is not a covered physical therapy service.

(11) Ultrasound, shortwave, and microwave diathermy treatments are considered covered services.

(12) Range of motion tests must be performed by a qualified physical therapist. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease or disabling condition which has resulted in a loss or restriction of mobility.

Documentation must reflect the degree of motion lost, the normal range of motion, and the degree to be restored.

Range of motion to unaffected joints only does not constitute a covered physical therapy service.

(13) Reconditioning programs after surgery or prolonged hospitalization are not covered as physical therapy.

(14) Therapeutic exercises would constitute a physical therapy service due either to the type of exercise employed or to the condition of the patient.

(15) Use of isokinetic or isotonic type equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament or tendon injury or postsurgical trauma. Billing can only be made for the time actually spent by the therapist in instructing the patient and assessing the patient's progress.

(16) When recipients do not meet restorative or maintenance therapy criteria, diagnostic or trial therapy may be utilized. When the initial evaluation is not sufficient to determine whether there are rehabilitative goals that should be addressed, diagnostic or trial therapy to establish goals shall be considered appropriate. Diagnostic or trial therapy may be appropriate for recipients who need evaluation in multiple environments in order to adequately determine their rehabilitative potential. Diagnostic or trial therapy consideration may be appropriate when there is a need to assess the patient's response to treatment in the recipient's environment.

When during diagnostic or trial therapy a recipient has been sufficiently evaluated to determine potential for restorative or maintenance therapy, or lack of therapy potential, diagnostic or trial therapy ends. When as a result of diagnostic or trial therapy, restorative or maintenance therapy is found appropriate, claims shall be submitted noting restorative or maintenance therapy (instead of diagnostic or trial therapy).

At the end of diagnostic or trial therapy, the rehabilitation provider shall recommend continuance of services under restorative therapy, recommend continuance of services under maintenance therapy, or recommend discontinuance of services. Continuance of services under restorative or maintenance therapy will be reviewed based on the criteria in place for restorative or maintenance therapy.

Trial therapy shall not be granted more often than once per year for the same issue. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. Requests for subsequent diagnostic or trial therapy for the same issue would require documentation reflecting a significant change. See number 4 below for guidelines under a significant change. Further diagnostic or trial therapy for the same issue would not be considered appropriate when progress was not achieved, unless the reasons which blocked change previously are listed and the reasons the new diagnostic or trial therapy would not have these blocks are provided.

The number of diagnostic or trial therapy hours authorized in the initial treatment period shall not exceed 12 hours per month. Documentation of the medical necessity and the plan for services under diagnostic trial therapy are required as they will be reviewed in the determination of the medical necessity of the number of hours of service provided.

Diagnostic or trial therapy standards also apply to speech and occupational therapy.

The following criteria additionally must be met:

1. There must be face-to-face interaction with a licensed therapist. (An aide's services will not be payable.)

2. Services must be provided on an individual basis. (Group diagnostic or trial therapy will not be payable.)

3. Documentation of the diagnostic therapy or trial therapy must reflect the provider's plan for therapy and the recipient's response.

4. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. A significant change would be considered as having occurred when any of the following exist: new onset, new problem, new need, new growth issue, a change in vocational or residential setting that requires a reevaluation of potential, or surgical intervention that may have caused new rehabilitative potentials.

5. For persons who received previous rehabilitative treatment, consideration of trial therapy generally should occur only if the person has incorporated any regimen recommended during prior treatment into the person's daily life to the extent of the person's abilities.

6. Documentation should include any previous attempts to resolve problems using nontherapy personnel (i.e., residential group home staff, family members, etc.) and whether follow-up programs from previous therapy have been carried out.

7. Referrals from residential, vocational or other rehabilitation personnel that do not meet present evaluation, restorative or maintenance criteria shall be considered for trial therapy. Documentation of the proposed service, the medical necessity and the current medical or disabling condition, including any secondary rehabilitative diagnosis, will need to be submitted with the claim.

8. Claims for diagnostic or trial therapy shall reflect the progress being made toward the initial diagnostic or trial therapy plan.

c. Occupational therapy services.

(1) To be covered under rehabilitation agency services, occupational therapy services must be included in a plan of treatment, improve or restore practical functions which have been impaired by illness, injury, or disabling condition, or enhance the person's ability to perform those tasks required for independent functioning, be prescribed by a physician under a plan of treatment, be performed by a qualified licensed occupational therapist or a qualified licensed occupational therapist assistant under the general supervision of a qualified licensed occupational therapist as set forth in the department of public health, professional licensure division, rule 645—201.9(148B), and be reasonable and necessary for the treatment of the person's illness, injury, or disabling condition.

(2) Restorative therapy is covered when an expectation exists that the therapy will result in a significant practical improvement in the person's condition.

However, in these cases where there is a valid expectation of improvement met at the time the occupational therapy program is instituted, but the expectation goal is not realized, services would only be covered up to the time one would reasonably conclude the patient would not improve.

The guidelines under restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1)*"b"*(7), (8), and (16) apply to occupational therapy.

(3) Maintenance therapy, or any activity or exercise program required to maintain a function at the restored level, is not a covered service. However, designing a maintenance program in accordance with the requirements of 78.19(1)*"b"*(8) and monitoring the progress would be covered.

(4) The selection and teaching of tasks designed to restore physical function are covered.

(5) Planning and implementing therapeutic tasks, such as activities to restore sensory-integrative functions are covered. Other examples include providing motor and tactile activities to increase input and improve responses for a stroke patient.

(6) The teaching of activities of daily living and energy conservation to improve the level of independence of a patient which require the skill of a licensed therapist and meet the definition of restorative therapy is covered.

(7) The designing, fabricating, and fitting of orthotic and self-help devices are considered covered services if they relate to the patient's condition and require occupational therapy. A maximum of 13 visits is reimbursable.

(8) Vocational and prevocational assessment and training are not payable by Medicaid. These include services which are related solely to specific employment opportunities, work skills, or work settings.

d. Speech therapy services.

(1) To be covered by Medicaid as rehabilitation agency services, speech therapy services must be included in a plan of treatment established by the licensed, skilled therapist after consultation with the physician, relate to a specific medical diagnosis which will significantly improve a patient's practical, functional level in a reasonable and predictable time period, and require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable.

(2) Speech therapy activities which are considered covered services include: restorative therapy services to restore functions affected by illness, injury, or disabling condition resulting in a communication impairment or to develop functions where deficiencies currently exist. Communication impairments fall into the general categories of disorders of voice, fluency, articulation, language, and swallowing disorders resulting from any condition other than mental impairment. Treatment of these conditions is payable if restorative criteria are met.

(3) Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to patients who have suffered a hearing loss (input impairment), constitutes a covered service if reasonable and necessary to the patient's illness or injury. Group treatment is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

(4) Teaching a patient to use sign language and to use an augmentative communication device is reimbursable. The patient must show significant progress outside the therapy sessions in order for these services to be reimbursable.

(5) Where a maintenance program is appropriate, the initial evaluation, the instruction of the patient and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable. However, designing a maintenance program in accordance with the requirements of maintenance therapy and monitoring the progress are covered.

(6) The guidelines and limits on restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1)*"b"*(7), (8), and (16) apply to speech therapy. If the only goal of prior rehabilitative speech therapy was to learn the prerequisite speech components, then number "5" under 78.19(1)*"b"*(16) will not apply to trial therapy.

78.19(2) *General guidelines for plans of treatment.*

a. The minimum information to be included on medical information forms and treatment plans includes:

(1) The patient's current medical condition and functional abilities, including any disabling condition.

(2) The physician's signature and date (within the certification period).

(3) Certification period.
(4) Patient's progress in measurable statistics. (Refer to 78.19(1)*"b"*(16).)
(5) The place services are rendered.
(6) Dates of prior hospitalization (if applicable or known).
(7) Dates of prior surgery (if applicable or known).
(8) The date the patient was last seen by the physician (if available).
(9) A diagnosis relevant to the medical necessity for treatment.
(10) Dates of onset of any diagnoses for which treatment is being rendered (if applicable).
(11) A brief summary of the initial evaluation or baseline.
(12) The patient's prognosis.
(13) The services to be rendered.
(14) The frequency of the services and discipline of the person providing the service.
(15) The anticipated duration of the services and the estimated date of discharge (if applicable).
(16) Assistive devices to be used.
(17) Functional limitations.
(18) The patient's rehabilitative potential and the extent to which the patient has been able to apply the skills learned in the rehabilitation setting to everyday living outside the therapy sessions.
(19) The date of the last episode of instability or the date of the last episode of acute recurrence of illness or symptoms (if applicable).
(20) Quantitative, measurable, short-term and long-term functional goals.
(21) The period of time of a session.
(22) Prior treatment (history related to current diagnosis) if available or known.

b. The information to be included when developing plans for teaching, training, and counseling include:
(1) To whom the services were provided (patient, family member, etc.).
(2) Prior teaching, training, or counseling provided.
(3) The medical necessity of the rendered services.
(4) The identification of specific services and goals.
(5) The date of the start of the services.
(6) The frequency of the services.
(7) Progress in response to the services.
(8) The estimated length of time the services are needed.

This rule is intended to implement Iowa Code section 249A.4.
[**ARC 0994C**, IAB 9/4/13, effective 11/1/13]

441—78.20(249A) Independent laboratories. Payment will be made for medically necessary laboratory services provided by laboratories that are independent of attending and consulting physicians' offices, hospitals, and critical access hospitals and that are certified to participate in the Medicare program.

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

441—78.21(249A) Rural health clinics. Payment will be made to rural health clinics for the same services payable under the Medicare program (Title XVIII of the Social Security Act). Payment will be made for sterilization in accordance with 78.1(16).

78.21(1) *Utilization review.* Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.21(2) *Risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.21(3) *Vaccines.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a rural health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.22(249A) Family planning clinics. Payments will be made on a fee schedule basis for services provided by family planning clinics.

78.22(1) Payment will be made for sterilization in accordance with 78.1(16).

78.22(2) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a family planning clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.23(249A) Other clinic services. Payment will be made on a fee schedule basis to facilities not part of a hospital, funded publicly or by private contributions, which provide medically necessary treatment by or under the direct supervision of a physician or dentist to outpatients.

78.23(1) *Sterilization.* Payment will be made for sterilization in accordance with 78.1(16).

78.23(2) *Utilization review.* Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.23(3) *Risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.23(4) *Vaccines.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.24(249A) Psychologists. Payment will be approved for services authorized by state law when they are provided by the psychologist in the psychologist's office, a hospital, nursing facility, or residential care facility.

78.24(1) Payment for covered services provided by the psychologist shall be made on a fee for service basis.

a. Payment shall be made only for time spent in face-to-face consultation with the client.

b. Time spent with clients shall be rounded to the quarter hour.

78.24(2) Payment will be approved for the following psychological procedures:

a. Individual outpatient psychotherapy or other psychological procedures not to exceed one hour per week or 40 hours in any 12-month period, or

b. Couple, marital, family, or group outpatient therapy not to exceed one and one-half hours per week or 60 hours in any 12-month period, or

c. A combination of individual and group therapy not to exceed the cost of 40 individual therapy hours in any 12-month period.

d. Psychological examinations and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress, not to exceed eight hours in any 12-month period.

e. Mileage at the same rate as in 78.1(8) when the following conditions are met:

(1) It is necessary for the psychologist to travel outside of the home community, and

(2) There is no qualified mental health professional more immediately available in the community, and

(3) The member has a medical condition which prohibits travel.

f. Covered procedures necessary to maintain continuity of psychological treatment during periods of hospitalization or convalescence for physical illness.

g. Procedures provided within a licensed hospital, residential treatment facility, day hospital, or nursing home as part of an approved treatment plan and a psychologist is not employed by the facility.

78.24(3) Payment will not be approved for the following services:

a. Psychological examinations performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.

b. Psychological examinations covered under Part B of Medicare, except for the Part B Medicare deductible and coinsurance.

c. Psychological examinations employing unusual or experimental instrumentation.

d. Individual and group psychotherapy without specification of condition, symptom, or complaint.

e. Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, or psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

78.24(4) Rescinded IAB 10/12/94, effective 12/1/94.

78.24(5) The following services shall require review by a consultant to the department.

a. Protracted therapy beyond 16 visits. These cases shall be reviewed following the sixteenth therapy session and periodically thereafter.

b. Any service which does not appear necessary or appears to fall outside the scope of what is professionally appropriate or necessary for a particular condition.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

441—78.25(249A) Maternal health centers. Payment will be made for prenatal and postpartum medical care, health education, and transportation to receive prenatal and postpartum services. Payment will be made for enhanced perinatal services for persons determined high risk. These services include additional health education services, nutrition counseling, social services, and one postpartum home visit. Maternal health centers shall provide trimester and postpartum reports to the referring physician. Risk assessment using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.25(1) *Provider qualifications.*

a. Prenatal and postpartum medical services shall be provided by a physician, a physician assistant, or a nurse practitioner employed by or on contract with the center. Medical services performed by maternal health centers shall be performed under the supervision of a physician. Nurse practitioners and physician assistants performing under the supervision of a physician must do so within the scope of practice of that profession, as defined by Iowa Code chapters 152 and 148C, respectively.

b. Rescinded IAB 12/3/08, effective 2/1/09.

c. Education services and postpartum home visits shall be provided by a registered nurse.

d. Nutrition services shall be provided by a licensed dietitian.

e. Psychosocial services shall be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community services, health or human development, health education, or individual and family studies.

78.25(2) *Services covered for all pregnant women.* Services provided may include:

a. Prenatal and postpartum medical care.

b. Health education, which shall include:

(1) Importance of continued prenatal care.

(2) Normal changes of pregnancy including both maternal changes and fetal changes.

(3) Self-care during pregnancy.

(4) Comfort measures during pregnancy.

(5) Danger signs during pregnancy.

(6) Labor and delivery including the normal process of labor, signs of labor, coping skills, danger signs, and management of labor.

(7) Preparation for baby including feeding, equipment, and clothing.

(8) Education on the use of over-the-counter drugs.

(9) Education about HIV protection.

c. Home visit.

d. Transportation to receive prenatal and postpartum services that is not payable under rule 441—78.11(249A) or 441—78.13(249A).

e. Dental hygiene services within the scope of practice as defined by the dental board at 650—paragraph 10.5(3)*"b."*

78.25(3) *Enhanced services covered for women with high-risk pregnancies.* Enhanced perinatal services may be provided to a patient who has been determined to have a high-risk pregnancy as documented by Form 470-2942, Medicaid Prenatal Risk Assessment. An appropriately trained physician or advanced registered nurse practitioner must be involved in staffing the patients receiving enhanced services.

Enhanced services are as follows:

a. Rescinded IAB 12/3/08, effective 2/1/09.

b. Education, which shall include as appropriate education about the following:

(1) High-risk medical conditions.

(2) High-risk sexual behavior.

(3) Smoking cessation.

(4) Alcohol usage education.

(5) Drug usage education.

(6) Environmental and occupational hazards.

c. Nutrition assessment and counseling, which shall include:

(1) Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information.

(2) Ongoing nutritional assessment.

(3) Development of an individualized nutritional care plan.

(4) Referral to food assistance programs if indicated.

(5) Nutritional intervention.

d. Psychosocial assessment and counseling, which shall include:

(1) A psychosocial assessment including: needs assessment, profile of client demographic factors, mental and physical health history and concerns, adjustment to pregnancy and future parenting, and environmental needs.

(2) A profile of the client's family composition, patterns of functioning and support systems.

(3) An assessment-based plan of care, risk tracking, counseling and anticipatory guidance as appropriate, and referral and follow-up services.

e. A postpartum home visit within two weeks of the child's discharge from the hospital, which shall include:

(1) Assessment of mother's health status.

(2) Physical and emotional changes postpartum.

(3) Family planning.

(4) Parenting skills.

(5) Assessment of infant health.

(6) Infant care.

(7) Grief support for unhealthy outcome.

(8) Parenting of a preterm infant.

(9) Identification of and referral to community resources as needed.

78.25(4) *Vaccines.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a maternal health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.26(249A) Ambulatory surgical center services. Ambulatory surgical center services are those services furnished by an ambulatory surgical center in connection with a covered surgical procedure or a covered dental procedure. Covered procedures are listed in the fee schedule published on the department's Web site.

78.26(1) Covered surgical procedures shall be those medically necessary procedures that are eligible for payment as physicians' services, under the circumstances specified in rule 441—78.1(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(2) Covered dental procedures are those medically necessary procedures that are eligible for payment as dentists' services, under the circumstances specified in rule 441—78.4(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting for Medicaid members whose mental, physical, or emotional condition necessitates deep sedation or general anesthesia.

78.26(3) The covered services provided by the ambulatory surgical center in connection with a Medicaid-covered surgical or dental procedure shall be those nonsurgical and nondental services that:

a. Are medically necessary in connection with a Medicaid-covered surgical or dental procedure;

b. Are eligible for payment as physicians' services under the circumstances specified in rule 441—78.1(249A) or as dentists' services under the circumstances specified in rule 441—78.4(249A); and

c. Can safely and economically be performed in an outpatient setting, as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(4) Limits on covered services.

a. Abortion procedures are covered only when criteria in subrule 78.1(17) are met.

b. Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.

c. Preprocedure review by the 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.

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, 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 member's case manager or integrated health home care coordinator has completed an assessment of the member's need for service, and based on that assessment, the IME medical services unit has determined that the member is in need of home- and community-based habilitation services. The designated case manager or integrated health home care coordinator shall:

(1) Complete a needs-based evaluation that meets the standards for assessment established in 441—subrule 90.5(1) before services begin and annually thereafter.

(2) Use the evaluation results to develop a comprehensive service plan as specified in subrule 78.27(4).

e. Plan for service. The department 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 for the member. The team shall include the case manager or integrated health home care coordinator and the member and, if applicable, the member's legal representative, the member's family, the member's service providers, and others directly involved.

(2) With the interdisciplinary team, the case manager or integrated health home care coordinator shall identify the member's services based on the member's needs, the availability of services, and the member's choice of services and providers.

(3) The comprehensive service plan development shall be completed at the member's home or at another location chosen by the member.

(4) The interdisciplinary team meeting shall be conducted before the current comprehensive service plan expires.

(5) The comprehensive service plan shall reflect desired individual outcomes.

(6) Services defined in the comprehensive service plan shall be appropriate to the severity of the member's problems and to the member's specific needs or disabilities.

(7) Activities identified in the comprehensive service plan shall encourage the ability and right of the member to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process.

(8) For members receiving home-based habilitation in a licensed residential care facility of 16 or fewer beds, the service plan shall address the member's opportunities for independence and community integration.

(9) The initial comprehensive service plan or treatment plan and annual updates to the comprehensive service plan or treatment plan must be approved by the 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, integrated health home care coordinator, or service worker within 30 calendar days after plan approval.

(10) Any changes to the comprehensive service plan or treatment plan must be approved by the 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 a nonresidential setting separate from the member's residence. Services shall not be provided in the member's home. When the member lives in a residential care facility of more than 16 beds, day habilitation services provided in the facility are not considered to be provided in the member's home if the services are provided in an area apart from the member's sleeping accommodations.

c. Duration. Day habilitation services shall be furnished for four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the member's comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

d. Exclusions. Day habilitation payment shall not be made for the following:

(1) Vocational or prevocational services.

(2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(3) Compensation to members for participating in day habilitation services.

78.27(9) *Prevocational service habilitation.* "Prevocational services" means services that provide career exploration, learning and work experiences, including volunteer opportunities, where the member can develop non-job-task-specific strengths and skills that lead to paid employment in individual community settings.

a. Scope. Prevocational services are provided to persons who are expected to be able to join the general workforce with the assistance of supported employment. Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment. These skills include but are not limited to the ability to communicate effectively with supervisors, coworkers and customers; an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training; the ability to navigate local transportation options; financial literacy skills; and skills related to obtaining employment.

Prevocational services include career exploration activities to facilitate successful transition to individual employment in the community. Participation in prevocational services is not a prerequisite for individual or small-group supported employment services.

(1) Career exploration. Career exploration activities are designed to develop an individual career plan and facilitate the member's experientially based informed choice regarding the goal of individual employment. Career exploration may be provided in small groups of no more than four members to participate in career exploration activities that include business tours, attending industry education events, benefit information, financial literacy classes, and attending career fairs. Career exploration may be authorized for up to 34 hours, to be completed over 90 days in the member's local community or nearby communities and may include but is not limited to the following activities:

1. Meeting with the member and the member's family, guardian or legal representative to introduce them to supported employment and explore the member's employment goals and experiences,
2. Business tours,
3. Informational interviews,
4. Job shadows,
5. Benefits education and financial literacy,
6. Assistive technology assessment, and
7. Job exploration events.

(2) Expected outcome of service.

1. The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the member interacts with individuals without disabilities, other than those providing services to the member or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

2. The expected outcome of the career exploration activity is a written career plan that will guide employment services which lead to community employment or self-employment for the member.

b. Setting. Prevocational services shall take place in community-based nonresidential settings.

c. Concurrent services. A member's individual service plan may include two or more types of nonresidential habilitation services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

d. Exclusions. Prevocational services payment shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving prevocational services.

(2) Services available to the individual that duplicate or replace education or related services defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

(3) Compensation to members for participating in prevocational services.

(4) Support for members volunteering in for-profit organizations and businesses other than for-profit organizations, or businesses that have formal volunteer programs in place (e.g., hospitals, nursing homes), and support for members volunteering to benefit the service provider.

(5) The provision of vocational services delivered in facility-based settings where individuals are supervised for the primary purpose of producing goods or performing services or where services are aimed at teaching skills for specific types of jobs rather than general skills.

(6) A prevocational service plan with the goal or purpose of the service documented as maintaining or supporting the individual in continuing prevocational services or any employment situation similar to sheltered employment.

e. Limitations.

(1) Time limitation for members starting prevocational services. For members starting prevocational services after May 4, 2016, participation in these services is limited to 24 calendar months. This time limit can be extended to continue beyond 24 months if one or more of the following conditions apply:

1. The member who is in prevocational services is also working in either individual or small-group community employment for at least the number of hours per week desired by the member, as identified in the member's current service plan; or

2. The member who is in prevocational services is also working in either individual or small-group community employment for less than the number of hours per week the member desires, as identified in the member's current service plan, but the member has services documented in the member's current service plan, or through another identifiable funding source (e.g., Iowa vocational rehabilitation services (IVRS)), to increase the number of hours the member is working in either individual or small-group community employment; or

3. The member is actively engaged in seeking individual or small-group community employment or individual self-employment, and services for this are included in the member's current service plan or services funded through another identifiable funding source (e.g., IVRS) are documented in the member's service plan; or

4. The member has requested supported employment services from Medicaid and IVRS in the past 24 months, and the member's request has been denied or the member has been placed on a waiting list by both Medicaid and IVRS; or

5. The member has been receiving individual supported employment services (or comparable services available through IVRS) for at least 18 months without obtaining individual or small-group community employment or individual self-employment; or

6. The member is participating in career exploration activities as described in subparagraph 78.27(9)*"a"*(1).

(2) Time limitation for members enrolled in prevocational services. For members enrolled in prevocational services on or before May 4, 2016, participation in these services is limited to 90 business days beyond the completion of the career exploration activity including the development of the career plan described in subparagraph 78.27(9)*"a"*(1). This time limit can be extended as stated in paragraphs 78.27(9)*"e"*(1)"1" through "6." If the criteria in paragraphs 78.27(9)*"e"*(1)"1" through "6" do not apply, the member will not be reauthorized to continue prevocational services.

78.27(10) *Supported employment services.*

a. Individual supported employment. Individual supported employment involves supports provided to, or on behalf of, the member that enable the member to obtain and maintain individual employment. Services are provided to members who need support because of their disabilities.

(1) Scope. Individual supported employment services are services provided to, or on behalf of, the member that enable the member to obtain and maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(2) Expected outcome of service. The expected outcome of this service is sustained employment, or self-employment, paid at or above the minimum wage or the customary wage and level of benefits paid by an employer, in an integrated setting in the general workforce, in a job that meets personal and career goals. Successful transition to long-term job coaching, if needed, is also an expected outcome of this service. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) Setting. Individual supported employment services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting where members are paid for the production of goods or services) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities or with the general public.

(4) Individual employment strategies include but are not limited to: customized employment, individual placement and support, and supported self-employment. Service activities are individualized and may include any combination of the following:

1. Benefits education.
2. Career exploration (e.g., tours, informational interviews, job shadows).
3. Employment assessment.
4. Assistive technology assessment.
5. Trial work experience.
6. Person-centered employment planning.
7. Development of visual/traditional résumés.
8. Job-seeking skills training and support.
9. Outreach to prospective employers on behalf of the member (e.g., job development; negotiation with prospective employers to customize, create or carve out a position for the member; employer needs analysis).
10. Job analysis (e.g., work site assessment or job accommodations evaluation).
11. Identifying and arranging transportation.
12. Career advancement services (e.g., assisting a member in making an upward career move or seeking promotion from an existing employer).
13. Reemployment services (if necessary due to job loss).
14. Financial literacy and asset development.

15. Other employment support services deemed necessary to enable the member to obtain employment.

16. Systematic instruction and support during initial on-the-job training including initial on-the-job training to stabilization.

17. Engagement of natural supports during initial period of employment.

18. Implementation of assistive technology solutions during initial period of employment.

19. Transportation of the member during service hours.

20. Initial on-the-job training to stabilization activity.

(5) Self-employment. Individual employment may also include support to establish a viable self-employment opportunity, including home-based self-employment. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. In addition to the activities listed under subparagraph 78.27(10)*"a"*(4), assistance to establish self-employment may include:

1. Aid to the member in identifying potential business opportunities.

2. Assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business.

3. Identification of the long-term supports necessary for the individual to operate the business.

b. Long-term job coaching. Long-term job coaching is support provided to, or on behalf of, the member that enables the member to maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(1) Scope. Long-term job coaching services are provided to or on behalf of members who need support because of their disabilities and who are unlikely to maintain and advance in individual employment absent the provision of supports. Long-term job coaching services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention and advancement.

(2) Expected outcome of service. The expected outcome of this service is sustained employment paid at or above the minimum wage in an integrated setting in the general workforce, in a job that meets the member's personal and career goals. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) Setting. Long-term job coaching services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities, or with the general public, and if the position would exist within the provider's organization were the provider not being paid to provide the job coaching to the member.

(4) Service activities. Long-term job coaching services are designed to assist the member with learning and retaining individual employment, resulting in workplace integration, and which allows for the reduction of long-term job coaching over time. Services are individualized, and service plans are adjusted as support needs change and may include any combination of the following activities with or on behalf of the member:

1. Job analysis.

2. Job training and systematic instruction.

3. Training and support for use of assistive technology/adaptive aids.

4. Engagement of natural supports.

5. Transportation coordination.

6. Job retention training and support.

7. Benefits education and ongoing support.

8. Supports for career advancement.

9. Financial literacy and asset development.

10. Employer consultation and support.

11. Negotiation with employer on behalf of the member (e.g., accommodations; employment conditions; access to natural supports; and wage and benefits).

12. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the job setting.

13. Transportation of the member during service hours.

14. Career exploration services leading to increased hours or career advancement.

(5) Self-employment long-term job coaching. Self-employment long-term job coaching may include support to maintain a self-employment opportunity, including home-based self-employment. In addition to the activities listed under subparagraph 78.27(10)*"b"*(4), assistance to maintain self-employment may include:

1. Ongoing identification of the supports necessary for the individual to operate the business;

2. Ongoing assistance, counseling and guidance to maintain and grow the business; and

3. Ongoing benefits education and support.

(6) The hours of support for long-term job coaching are based on the identified needs of the member as documented in the member's comprehensive service plan.

c. Small-group supported employment. Small-group supported employment services are training and support activities provided in regular business or industry settings for groups of two to eight workers with disabilities. The outcome of this service is sustained paid employment experience, skill development, career exploration and planning leading to referral for services to obtain individual integrated employment or self-employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

(1) Scope. Small-group supported employment services must be provided in a manner that promotes integration into the workplace and interaction between members and people without disabilities (e.g., customers, coworkers, natural supports) in those workplaces. Examples include but are not limited to mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in integrated business settings; and small-group activities focused on career exploration and development of strengths and skills that contribute to successful participation in individual community employment.

(2) Expected outcome of service. Small-group supported employment services are expected to enable the member to make reasonable and continued progress toward individual employment. Participation in small-group supported employment services is not a prerequisite for individual supported employment services. The expected outcome of the service is sustained paid employment and skill development which leads to individual employment in the community.

(3) Setting. Small-group supported employment services shall take place in integrated, community-based nonresidential settings separate from the member's residence.

(4) Service activities. Small-group supported employment services may include any combination of the following activities:

1. Employment assessment.

2. Person-centered employment planning.

3. Job placement (limited to service necessary to facilitate hire into individual employment paid at minimum wage or higher for a member in small-group supported employment who receives an otherwise unsolicited offer of a job from a business where the member has been working in a mobile crew or enclave).

4. Job analysis.

5. On-the-job training and systematic instruction.

6. Job coaching.

7. Transportation planning and training.

8. Benefits education.

9. Career exploration services leading to career advancement outcomes.

10. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the individual or community setting.

11. Transportation of the member during service hours.

d. Service requirements for all supported employment services.

(1) Community transportation options (e.g., transportation provided by family, coworkers, carpools, volunteers, self or public transportation) shall be identified by the member's interdisciplinary team and utilized before the service provider provides the transportation to and from work for the member. If none of these options are available to a member, transportation between the member's place of residence and the employment or service location may be included as a component part of supported employment services.

(2) Personal care or personal assistance and protective oversight may be a component part of supported employment services, but may not comprise the entirety of the service.

(3) Activities performed on behalf of a member receiving long-term job coaching or individual or small-group supported employment shall not comprise the entirety of the service.

(4) Concurrent services. A member's individual service plan may include two or more types of nonresidential services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

(5) Integration requirements. In the performance of job duties, the member shall have regular contact with other employees or members of the general public who do not have disabilities, unless the absence of regular contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(6) Compensation. Members receiving these services are compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. For supported self-employment, the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. For small-group supported employment, if the member is not compensated at or above minimum wage, the compensation to the member shall be in accordance with all applicable state and federal labor laws and regulations.

e. Limitations. Supported employment services are limited as follows:

(1) Total monthly costs of supported employment may not exceed the monthly cap on the cost of waiver services set for the individual waiver program.

(2) In absence of a monthly cap on the cost of waiver services, the total monthly cost of all supported employment services may not exceed $3,059.29 per month.

(3) Individual supported employment is limited to 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.

f. Exclusions. Supported employment services payments shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that the service is not available to the individual under these programs shall be maintained in the service plan of each member receiving individual supported employment or long-term job coaching services.

(2) Incentive payments, not including payments for coworker supports, made to an employer to encourage or subsidize the employer's participation in a supported employment program.

(3) Subsidies or payments that are passed through to users of supported employment programs.

(4) Training that is not directly related to a member's supported employment program.

(5) Services involved in placing and stabilizing members in day activity programs, work activity programs, sheltered workshop programs or other similar types of vocational or prevocational services furnished in specialized facilities that are not a part of the general workplace.

(6) Supports for placement and stabilization in volunteer positions or unpaid internships. Such volunteer learning and unpaid training activities that prepare a person for entry into the general workforce are addressed through prevocational services and career exploration activities.

(7) Tuition for education or vocational training.

(8) Individual advocacy that is not related to integrated individual employment participation or is not member-specific.

(9) Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

78.27(11) *Adverse service actions.*

a. Denial. Services shall be denied when the department determines that:

(1) The member is not eligible for or in need of home- and community-based habilitation services.

(2) The service is not identified in the member's comprehensive service plan or treatment plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(5) Completion or receipt of required documents for the program has not occurred.

b. Reduction. A particular home- and community-based habilitation service may be reduced when the department determines that continued provision of service at its current level is not necessary.

c. Termination. A particular home- and community-based habilitation service may be terminated when the department determines that:

(1) The member's income exceeds the allowable limit, or the member no longer meets other eligibility criteria for the program established by the department.

(2) The service is not identified in the member's comprehensive service plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs are not being met by the services provided.

(5) The member has received care in a medical institution for 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]

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

78.28(2) Dental services. Dental services which require prior approval are as follows:

a. The following periodontal services:

(1) Periodontal scaling and root planing. Payment will be approved pursuant to the criteria at 78.4(4)*"b."*

(2) Pedicle soft tissue graft, free soft tissue graft, and subepithelial tissue graft. Payment will be approved pursuant to the criteria at 78.4(4)*"d."*

(3) Periodontal maintenance therapy. Payment will be approved pursuant to the criteria at 78.4(4)*"e."*

(4) Tissue regeneration. Payment will be approved pursuant to the criteria at 78.4(4)*"f."*

(5) Localized delivery of antimicrobial agents. Payment will be approved pursuant to the criteria at 78.4(4)*"g."*

b. The following prosthetic services:

(1) A removable partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)*"b."*

(2) A fixed partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)*"d."*

(3) A removable partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)*"c."*

(4) A fixed partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)*"e."*

(5) Dental implants and related services. Payment will be approved pursuant to the criteria at 78.4(7)*"k."*

(6) Replacement of complete or partial dentures in less than a five-year period. Payment will be approved pursuant to the criteria at 78.4(7)*"l."*

(7) A complete or partial denture rebase. Payment will be approved pursuant to the criteria at 78.4(7)*"m."*

(8) An oral appliance for obstructive sleep apnea. Payment will be approved pursuant to the criteria at 78.4(7)*"n."*

c. The following orthodontic services:

(1) Minor treatment to control harmful habits. Payment will be approved pursuant to the criteria at 78.4(8)*"a."*

(2) Interceptive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8)*"b."*

(3) Comprehensive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8)*"c."*

d. The following restorative services:

(1) Laboratory-fabricated crowns other than stainless steel. Payment will be approved pursuant to the criteria at 78.4(3)*"d"*(3).

(2) Crowns with noble or high noble metals. Payment will be approved pursuant to the criteria at 78.4(3)*"d"*(4).

e. Endodontic retreatment of a tooth. Payment will be approved pursuant to the criteria at 78.4(5)*"d."*

f. Occlusal guard. Payment will be approved pursuant to the criteria at 78.4(9)*"g."*

78.28(3) Optometric services and ophthalmic materials which must be submitted for prior approval are as follows:

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

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

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

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

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

For all of the above, the optometrist shall furnish sufficient information to clearly establish that these procedures are necessary in terms of the visual condition of the patient. (Cross references 78.6(4), 441—78.7(249A), and 78.1(18))

78.28(4) Hearing aids that must be submitted for prior approval are:

a. Replacement of a hearing aid less than four years old (except when the member is under 21 years of age). The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person's hearing that would require a different hearing aid. (Cross reference 78.14(7)*"d"*(1))

b. A hearing aid costing more than $650. The department shall approve payment for either of the following purposes (Cross reference 78.14(7)*"d"*(2)):

(1) Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

(2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

78.28(5) Hospital services which must be subject to prior approval, preprocedure review or preadmission review are:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the hospital as long as the approval is obtained by the physician. (Cross reference 441—78.1(249A))

b. All inpatient hospital admissions are subject to 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.

[**ARC 7548B**, IAB 2/11/09, effective 4/1/09; **ARC 8714B**, IAB 5/5/10, effective 5/1/10; **ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 9702B**, IAB 9/7/11, effective 9/1/11; **ARC 9883B**, IAB 11/30/11, effective 1/4/12; **ARC 0305C**, IAB 9/5/12, effective 11/1/12; **ARC 0631C**, IAB 3/6/13, effective 5/1/13; **ARC 0632C**, IAB 3/6/13, effective 5/1/13; **ARC 0823C**, IAB 7/10/13, effective 9/1/13; **ARC 1151C**, IAB 10/30/13, effective 1/1/14; **ARC 1696C**, IAB 10/29/14, effective 1/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—78.29(249A) Behavioral health services. Payment shall be made for medically necessary behavioral health services provided by a participating marital and family therapist, independent social worker, master social worker, mental health counselor, or certified alcohol and drug counselor within the practitioner's scope of practice pursuant to state law and subject to the limitations and exclusions set forth in this rule.

78.29(1) *Limitations.*

a. An assessment and a treatment plan are required.

b. Services provided by a licensed master social worker must be provided under the supervision of an independent social worker qualified to participate in the Medicaid program.

78.29(2) *Exclusions.* Payment will not be approved for the following services:

a. Services provided in a medical institution.

b. Services performed without relationship to a specific condition, risk factor, symptom, or complaint.

c. Services provided for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

d. Sensitivity training, marriage enrichment, assertiveness training, and growth groups or marathons.

78.29(3) *Payment.*

a. Payment shall be made only for time spent in face-to-face consultation with the member.

b. A unit of service is 15 minutes. Time spent with members shall be rounded to the quarter hour, where applicable.

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

[**ARC 9649B**, IAB 8/10/11, effective 8/1/11]

441—78.30(249A) Birth centers. Payment will be made for prenatal, delivery, and postnatal services.

78.30(1) *Risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.30(2) *Vaccines.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a birth center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.31(249A) Hospital outpatient services.

78.31(1) *Covered hospital outpatient services.* Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital or pursuant to subrule 78.31(5). Hospitals with alternate sites approved by the department of inspections and appeals are acceptable sites. All outpatient services listed in paragraphs *"g"* to *"m"* are subject to a random sample retrospective review for medical necessity by the IME medical services unit. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs *"a"* to *"f"* shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs *"g"* to *"m"* shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

a. Emergency service.
b. Outpatient surgery.
c. Laboratory, X-ray and other diagnostic services.
d. General or family medicine.
e. Follow-up or after-care specialty clinics.
f. Physical medicine and rehabilitation.
g. Alcoholism and substance abuse.
h. Eating disorders.
i. Cardiac rehabilitation.
j. Mental health.
k. Pain management.
l. Diabetic education.
m. Pulmonary rehabilitation.
n. Nutritional counseling for persons aged 20 and under.

78.31(2) *Requirements for all outpatient services.*

a. Need for service. It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

b. Professional direction. All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

c. Goals and objectives. The goals and objectives of the program must be clearly stated. Paragraphs *"d"* and *"f"* and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

d. Treatment modalities used. The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

e. Criteria for selection and continuing treatment of patients. The condition or disease which is proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

f. Length of program. There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

g. Monitoring of services. The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

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

78.31(3) *Application for certification.* Hospital outpatient programs listed in subrule 78.31(1), paragraphs *"g"* to *"m,"* must submit an application to the Iowa Medicaid enterprise provider services unit for certification before payment will be made. The provider services unit will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

a. Documented need for the program including studies, needs assessments, and consultations with other health care professionals.

b. Goals and objectives of the program.

c. Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff's relationship to the program, e.g., hospital employee, contractual consultant.

d. Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.

e. Any accreditations or other types of approvals from national or state organizations.

f. The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

78.31(4) *Requirements for specific types of service.*

a. Alcoholism and substance abuse.

(1) Approval by joint commission or substance abuse commission. In addition to certification by the department, alcoholism and substance abuse programs must also be approved by either the joint commission on the accreditation of hospitals or the Iowa substance abuse commission.

(2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient's dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, gender, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups, including but not limited to, learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

(3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance abuse counselor certified by the Iowa board of substance abuse certification. Psychiatric consultation must be available and the number of staff should be appropriate to the patient load of the facility.

(4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted which shall include:

A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.

A comprehensive medical history and physical examination including the history of physical problems associated with dependence.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

Any history of physical abuse.

A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of alcoholism and other drug dependencies.

The patient's educational level, vocational status, and job performance history.

The patient's social support networks, including family and peer relationships.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and in programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission.

Legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

Alcohol or drugs taken in greater amounts over a longer period than the person intended.

Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.

Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.

Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.

Characteristic withdrawal symptoms.

Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

(6) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level.

If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

b. Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa or bulimia nervosa. Compulsive overeaters are not approved for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master's or bachelor's degree and experience,

a dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient's eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

A history of exercise behavior, including type, frequency, and duration.

A complete history of current alcohol and other drug use.

Any suicidal thoughts or attempts.

Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.

History of experiencing physical or sexual (incest or rape) abuse.

History of other counseling experiences.

Appropriate psychological assessment, including psychological orientation to the above questions.

A medical history, including a physical examination, covering the information listed in subparagraph (4) below.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

The patient's social support networks, including family and peer relationships.

The patient's educational level, vocational status, and job or school performance history, as appropriate.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission as appropriate.

Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia nervosa as established by the current version of the DSM (Diagnostic and Statistical Manual of Mental Disorders) published by the American Psychiatric Association.

In addition to the diagnostic criteria, the need for treatment will be determined by a demonstrable loss of control of eating behaviors and the failure of the patient in recent attempts at voluntary self-control of the problem. Demonstrable impairment, dysfunction, disruption or harm of physical health, emotional health (e.g., significant depression withdrawal, isolation, suicidal ideas), vocational or educational functioning, or interpersonal functioning (e.g., loss of relationships, legal difficulties) shall have occurred.

The need for treatment may be further substantiated by substance abuse, out-of-control spending, incidence of stealing to support habit, or compulsive gambling.

The symptoms shall have been present for at least six months and three of the following criteria must be present:

Medical criteria including endocrine and metabolic factors (e.g., amenorrhea, menstrual irregularities, decreased reflexes, cold intolerance, hypercarotenemia, parotid gland enlargement, lower respiration rate, hair loss, abnormal cholesterol or triglyceride levels).

Other cardiovascular factors including hypotension, hypertension, arrhythmia, ipecac poisoning, fainting, or bradycardia.

Renal considerations including diuretic abuse, dehydration, elevated BUN, renal calculi, edema, or hypokalemia.

Gastrointestinal factors including sore throats, mallery-weiss tears, decreased gastric emptying, constipation, abnormal liver enzymes, rectal bleeding, laxative abuse, or esophagitis.

Hematologic considerations including anemia, leukopenia, or thrombocytopenia.

Ear, nose, and throat factors including headaches or dizziness.

Skin considerations including lanugo or dry skin.

Aspiration pneumonia, a pulmonary factor.

The presence of severe symptoms and complications as evaluated and documented by the medical director may require a period of hospitalization to establish physical or emotional stability.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perceptions of needs and, when appropriate and available, the family's perceptions of the patient's needs shall be documented.

The patient's participation in the development of the treatment plans is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. Plans for discharge shall meet the requirements for discharge plans for alcohol and substance abuse patients in subrule 78.31(3), paragraph *"a,"* subparagraph (6).

(7) Restriction and limitations on payment. Medicaid will pay for a maximum of 30 days of a structured outpatient treatment program. Payment beyond 30 days is made when documentation indicates that the patient has not reached an exit level.

Eating disorder programs will include an aftercare component meeting weekly for at least one year without charge.

Family counseling groups held in conjunction with the eating disorders program will be part of the overall treatment charge.

c. Cardiac rehabilitation.

(1) General characteristics. Cardiac rehabilitation programs shall provide a supportive educational environment in which to facilitate behavior change with respect to the accepted cardiac risk factors, initiate prescribed exercise as a mode of facilitating the return of the patient to everyday activities by improving cardiovascular functional capacity and work performance, and promote a long-term commitment to lifestyle changes that could positively affect the course of the cardiovascular disease process.

(2) Treatment staff. Professional disciplines who must be represented on the treatment staff, either by employment by the facility (full-time or part-time), contract or referral, are as follows:

At least one physician responsible for responding to emergencies must be physically present in the hospital when patients are receiving cardiac rehabilitation services. The physician must be trained and certified at least to the level of basic life support.

A medical consultant shall oversee the policies and procedures of the outpatient cardiac rehabilitation area. The director shall meet with the cardiac rehabilitation staff on a regular basis to review exercise prescriptions and any concerns of the team.

A cardiac rehabilitation nurse shall carry out the exercise prescription after assessment of the patient. The nurse shall be able to interpret cardiac disrhythmia 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 patients and their families need to help determine and fully understand the goals, so that they realistically approach the treatment phase.

Patients are reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

Components of pulmonary rehabilitation to be included are physical therapy and relaxation techniques, exercise conditioning or physical conditioning for those with exercise limitations, respiratory therapy, education, an emphasis on the importance of smoking cessation, and nutritional information.

(6) Discharge plan. Ongoing care will generally be the responsibility of the primary care physician. Periodic reassessment will be conducted to evaluate progress and allow for educational reinforcement.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of 25 treatment days. Payment beyond 25 days is made when documentation indicates that the patient has not reached an exit level.

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

78.31(5) *Services rendered by advanced registered nurse practitioners certified in family, pediatric, or psychiatric mental health specialties and employed by a hospital.* Rescinded IAB 10/15/03, effective 12/1/03.

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

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—78.32(249A) Area education agencies. Payment will be made for physical therapy, occupational therapy, psychological evaluations and counseling, psychotherapy, speech-language therapy, and audiological, nursing, and vision services provided by an area education agency (AEA). Services shall be provided directly by the AEA or through contractual arrangement with the AEA.

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

441—78.33(249A) Case management services. Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

1. Members who are 18 years of age or over and have a primary diagnosis of intellectual disability, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).

2. Members who are under 18 years of age and are receiving services under the HCBS intellectual disability waiver or children's mental health waiver.

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

[**ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9588B**, IAB 6/29/11, effective 9/1/11; **ARC 0848C**, IAB 7/24/13, effective 7/1/13; **ARC 1051C**, IAB 10/2/13, effective 11/6/13; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—78.34(249A) HCBS ill and handicapped waiver services. Payment will be approved for the following services to members eligible for HCBS ill and handicapped waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

78.34(1) *Homemaker services.* Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

c. Meal preparation: planning and preparing balanced meals.

78.34(2) *Home health services.* Home health services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit.

a. Components of the service include, but are not limited to:

(1) Observation and reporting of physical or emotional needs.

(2) Helping a client with bath, shampoo, or oral hygiene.

(3) Helping a client with toileting.

(4) Helping a client in and out of bed and with ambulation.

(5) Helping a client reestablish activities of daily living.

(6) Assisting with oral medications ordered by the physician which are ordinarily self-administered.

(7) Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

(8) Accompaniment to medical services or transport to and from school.

b. In some cases, a nurse may provide home health services if the health of the client is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency's Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.

c. Skilled nursing care is not covered.

78.34(3) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.34(4) *Nursing care services.* Nursing care services are services which are included in the plan of treatment approved by the physician and which are provided by licensed nurses to consumers in the home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. A unit of service is a visit.

78.34(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be

used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite, or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.34(6) *Counseling services.* Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.34(7) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.34(7)*"f"* and the skilled activities listed in paragraph 78.34(7)*"g."* Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)*"b,"* the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.34(8) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.34(9) *Home and vehicle modification.* Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. 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 maximum of two meals is allowed per day. A unit of service is a meal.

78.34(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.34(13) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS health and disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Home-delivered meals.
4. Homemaker service.
5. Basic individual respite care.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.34(13)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13)*"b"*(3).

(6) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph 78.34(13)*"b"*(2) or the utilization adjustment factor in subparagraph 78.34(13)*"b"*(3). Anticipated costs for home and vehicle modification shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.

16. Room and board, including rent or mortgage payments.

17. School tuition.

18. Service animals.

19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.34(13)*"d."* The savings plan shall meet the requirements in paragraph 78.34(13)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.

2. The amount of the individual budget allocated each month to the savings plan.

3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,

2. Be medically necessary, and

3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement

rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7)*"b"* must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7)*"b,"* the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.34(14) *General service standards.* All ill and handicapped waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 2848C**, IAB 12/7/16, effective 11/15/16]

441—78.35(249A) Occupational therapist services. Payment will be approved for the same services provided by an occupational therapist that are payable under Title XVIII of the Social Security Act (Medicare).

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

441—78.36(249A) Hospice services.

78.36(1) *General characteristics.* A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A hospice provides palliative and supportive services to meet the physical, psychosocial, social and spiritual needs of a terminally ill individual and the individual's family or other persons caring for the individual regardless of where the individual resides. Hospice services are those services to control pain and provide support to individuals to continue life with as little disruption as possible.

a. Covered services. Covered services shall include, in accordance with Medicare guidelines, the following:

(1) Nursing care.

(2) Medical social services.

(3) Physician services.

(4) Counseling services provided to the terminally ill individual and the individual's family members or other persons caring for the individual at the individual's place of residence, including bereavement, dietary, and spiritual counseling.

(5) Short-term inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas for pain control, symptom management and respite purposes.

(6) Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the individual's terminal illness and related conditions, except for "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

(7) Homemaker and home health aide services.

(8) Physical therapy, occupational therapy and speech-language pathology unless this provision has been waived under the Medicare program for a specific provider.

(9) Other items or services specified in the resident's plan that would otherwise be paid under the Medicaid program.

Nursing care, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. The hospice may contract with other providers to provide the remaining services. Bereavement counseling, consisting of counseling services provided after the

individual's death to the individual's family or other persons caring for the individual, is a required hospice service but is not reimbursable.

b. Noncovered services.

(1) Covered services not related to the terminal illness. In accordance with Medicare guidelines, all medical services related to the terminal illness are the responsibility of the hospice. Services unrelated to the terminal illness are to be billed separately by the respective provider.

(2) Administrative duties performed by the medical director, any hospice-employed physician, or any consulting physician are included in the normal hospice rates. Patient care provided by the medical director, hospice-employed physician, attending physician, or consulting physician is separately reimbursable. Payment to the attending or consulting physician includes other partners in practice.

(3) Hospice care provided by a hospice other than the hospice designated by the individual unless provided under arrangements made by the designated hospice.

(4) AZT (Retrovir) and other curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

78.36(2) *Categories of care.* Hospice care entails the following four categories of daily care. Guidelines for core and other services must be adhered to for all categories of care.

a. Routine home care is care provided in the place of residence that is not continuous.

b. Continuous home care is provided only during a period of crisis when an individual requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care per day must be provided during a 24-hour day to qualify as continuous care. Homemaker and aide services may also be provided to supplement the nursing care.

c. Inpatient respite care is provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the individual is a resident of a nursing facility.

d. General inpatient care is provided in periods of acute medical crisis when the individual is hospitalized or in a participating hospice inpatient unit or nursing facility for pain control or acute or chronic symptom management.

78.36(3) *Residence in a nursing facility.* For purposes of the Medicaid hospice benefit, a nursing facility can be considered the residence of a beneficiary. When the person does reside in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

a. The resident is terminally ill.

b. The resident has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.

c. The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

78.36(4) *Approval for hospice benefits.* Payment will be approved for hospice services to individuals who are certified as terminally ill, that is, the individuals have a medical prognosis that their life expectancy is six months or less if the illness runs its normal course, and who elect hospice care rather than active treatment for the illness.

a. Physician certification process. The hospice must obtain certification that an individual is terminally ill in accordance with the following procedures:

(1) The hospice may obtain verbal orders to initiate hospice service from the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The verbal order shall be noted in the patient's record. The verbal order must be given within two days of the start of care and be followed up in writing no later than eight calendar days after hospice care is initiated. The certification must include the

statement that the individual's medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

(2) When verbal orders are not secured, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less, if the illness runs its normal course.

(3) Hospice care benefit periods consist of up to two periods of 90 days each and an unlimited number of subsequent 60-day periods as elected by the individual. The medical director or a physician must recertify at the beginning of each benefit period that the individual is terminally ill.

b. Election procedures. Individuals who are dually eligible for Medicare and Medicaid must receive hospice coverage under Medicare.

(1) Election statement. An individual, or individual's representative, elects to receive the hospice benefit by filing an election statement, Form 470-2618, Election of Medicaid Hospice Benefit, with a particular hospice. The hospice may provide the individual with another election form to use provided the form includes the following information:

1. Identification of the hospice that will provide the care.
2. Acknowledgment that the recipient has been given a full understanding of hospice care.
3. Acknowledgment that the recipient waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.
4. Acknowledgment that recipients are not responsible for copayment or other deductibles.
5. The recipient's Medicaid number.
6. The effective date of election.
7. The recipient's signature.

(2) Change of designation. An individual may change the designation of the particular hospice from which the individual elects to receive hospice care one time only.

(3) Effective date. An individual may designate an effective date for the hospice benefit that begins with the first day of the hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

(4) Duration of election. The election to receive hospice care will be considered to continue until one of the following occurs:

1. The individual dies.
2. The individual or the individual's representative revokes the election.
3. The individual's situation changes so that the individual no longer qualifies for the hospice benefit.
4. The hospice elects to terminate the recipient's enrollment in accordance with the hospice's established discharge policy.

(5) Revocation. Form 470-2619, Revocation of Medicaid Hospice Benefit, is completed when an individual or the individual's representative revokes the hospice benefit allowed under Medicaid. When an individual revokes the election of Medicaid coverage of hospice care, the individual resumes Medicaid coverage of the benefits waived when hospice care was elected.

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

441—78.37(249A) HCBS elderly waiver services. Payment will be approved for the following services to members eligible for the HCBS elderly waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

78.37(1) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25

to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.37(2) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.37(3) *Home health aide services.* Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service include:

a. Observation and reporting of physical or emotional needs.

b. Helping a client with bath, shampoo, or oral hygiene.

c. Helping a client with toileting.

d. Helping a client in and out of bed and with ambulation.

e. Helping a client reestablish activities of daily living.

f. Assisting with oral medications ordinarily self-administered and ordered by a physician.

g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.37(4) *Homemaker services.* Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

c. Meal preparation: planning and preparing balanced meals.

78.37(5) *Nursing care services.* Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services are reasonable and necessary to the treatment of an illness or injury

and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous, hypodermoclysis, and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services and informing the physician and other personnel of changes in the patient's condition and needs.

A unit of service is one visit. Nursing care service can pay for a maximum of eight nursing visits per month for intermediate level of care persons. There is no limit on the maximum visits for skilled level of care persons.

78.37(6) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.37(7) *Chore services.* Chore services provide assistance with the household maintenance activities listed in paragraph 78.37(7)*"a,"* as necessary to allow a member to remain in the member's own home safely and independently. A unit of service is 15 minutes.

a. Chore services are limited to the following services:

(1) Window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows;

(2) Minor repairs to walls, floors, stairs, railings and handles;

(3) Heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care, painting, and trash removal;

(4) Lawn mowing and removal of snow and ice from sidewalks and driveways.

b. Leaf raking, bush and tree trimming, trash burning, stick removal, and tree removal are not covered services.

78.37(8) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.37(9) *Home and vehicle modification.* Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial

need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.37(10) *Mental health outreach.* Mental health outreach services are services provided in a recipient's home to identify, evaluate, and provide treatment and psychosocial support. The services

can only be provided on the basis of a referral from the consumer's interdisciplinary team established pursuant to 441—subrule 83.22(2). A unit of service is 15 minutes.

78.37(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.37(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.37(13) *Assistive devices.* Assistive devices means practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence. They include, but are not limited to: long-reach brush, extra long shoehorn, nonslip grippers to pick up and reach items, dressing aids, shampoo rinse tray and inflatable shampoo tray, double-handled cup and sipper lid. A unit is an item.

a. The service shall be included in the member's service plan and shall exceed the services available under the Medicaid state plan.

b. The service shall be provided following prior approval by the Iowa Medicaid enterprise.

c. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.37(14) *Senior companion.* Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is 15 minutes.

78.37(15) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.37(15)*"f"* and the skilled activities listed in paragraph 78.37(15)*"g."* Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual, agency or assisted living facility that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Assisted living agreements with Iowa Medicaid members must specify the services to be considered covered under the assisted living occupancy agreement and those CDAC services to be covered under the elderly waiver. The funding stream for each service must be identified.

(3) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)*"b,"* the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care individual and agency providers must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Assisted living facilities may choose to use Form 470-4389 or may devise another system that adheres to the requirements of rule 441—79.3(249A). Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual, agency or assisted living facility. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.37(16) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS elderly waiver are:

1. Assistive devices.

2. Chore service.
3. Consumer-directed attendant care (unskilled).
4. Home and vehicle modification.
5. Home-delivered meals.
6. Homemaker service.
7. Basic individual respite care.
8. Senior companion.
9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.37(16)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.37(16)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.37(16)*"b"*(3).

(6) Anticipated costs for home and vehicle modification and assistive devices are not subject to the average cost in subparagraph 78.37(16)*"b"*(2) or the utilization adjustment factor in subparagraph 78.37(16)*"b"*(3). Anticipated costs for home and vehicle modification and assistive devices shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications and assistive devices shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification and assistive devices may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.

2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.

3. Be accommodated within the member's budget without compromising the member's health and safety.

4. Be provided to the member or directed exclusively toward the benefit of the member.

5. Be the least costly to meet the member's needs.

6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.37(16)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.

2. Clothing not related to an assessed medical need.

3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.

4. Costs associated with shipping items to the member.

5. Experimental and non-FDA-approved medications, therapies, or treatments.

6. Goods or services covered by other Medicaid programs.

7. Home furnishings.

8. Home repairs or home maintenance.

9. Homeopathic treatments.

10. Insurance premiums or copayments.

11. Items purchased on installment payments.

12. Motorized vehicles.

13. Nutritional supplements.

14. Personal entertainment items.

15. Repairs and maintenance of motor vehicles.

16. Room and board, including rent or mortgage payments.

17. School tuition.

18. Service animals.

19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or assistive device. When authorized, the budget may include an amount allocated for a home or vehicle modification or an assistive device. Before becoming part of the individual budget, all home and vehicle modifications and assistive devices shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or device.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.37(16)*"d."* The savings plan shall meet the requirements in paragraph 78.37(16)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7)*"b"* must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7)*"b,"* the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.37(17) *Case management services.* Case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member. Case management is provided at the direction of the member and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. Case management shall not include the provision of direct services by the case managers.

c. Payment for case management shall not be made until the consumer is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the consumer during a month when the consumer is enrolled.

78.37(18) *Assisted living service.* The assisted living service includes unanticipated and unscheduled personal care and supportive services that are furnished to waiver participants who reside in a homelike, noninstitutional setting. The service includes the 24-hour on-site response capability to meet unpredictable member needs as well as member safety and security through incidental supervision. Assisted living service is not reimbursable if performed at the same time as any service included in an approved consumer-directed attendant care (CDAC) agreement.

a. A unit of service is one day.

b. A day of assisted living service is billable only if both the following requirements are met:

(1) The member was present in the facility during that day's bed census.

(2) The assisted living provider has documented at least one assisted living service encounter for that day, in accordance with rule 441—79.3(249A). The documentation must include the member's response to the service. The documented assisted living service cannot also be an authorized CDAC service.

78.37(19) *General service standards.* All elderly waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0545C**, IAB 1/9/13, effective 3/1/13; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 2050C**, IAB 7/8/15, effective 7/1/15; **ARC 2340C**, IAB 1/6/16, effective 2/10/16]

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to members eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

78.38(1) *Counseling services.* Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care, and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.38(2) *Home health aide services.* Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service are:

a. Observation and reporting of physical or emotional needs.

b. Helping a client with bath, shampoo, or oral hygiene.

c. Helping a client with toileting.

d. Helping a client in and out of bed and with ambulation.

e. Helping a client reestablish activities of daily living.

f. Assisting with oral medications ordinarily self-administered and ordered by a physician.

g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.38(3) *Homemaker services.* Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

c. Meal preparation: planning and preparing balanced meals.

78.38(4) *Nursing care services.* Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services; and informing the physician and other personnel of changes in the patient's conditions and needs. A unit of service is a visit.

78.38(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.38(6) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.38(7) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.38(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited

to the nonskilled activities listed in paragraph 78.38(8)*"f"* and the skilled activities listed in paragraph 78.38(8)*"g."* Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)*"b,"* the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.38(9) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS AIDS/HIV waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home-delivered meals.
3. Homemaker service.
4. Basic individual respite care.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.38(9)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.38(9)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.38(9)*"b"*(3).

(6) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and

community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.38(9)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved

by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.38(9)*"d."* The savings plan shall meet the requirements in paragraph 78.38(9)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7)*"b"* must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7)*"b,"* the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.38(10) *General service standards.* All AIDS/HIV waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 1610C**, IAB 9/3/14, effective 8/13/14]

441—78.39(249A) Federally qualified health centers. Payment shall be made for services as defined in Section 1905(a)(2)(C) of the Social Security Act.

78.39(1) *Utilization review.* Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.39(2) *Risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.39(3) *Vaccines.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a federally qualified health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.40(249A) Advanced registered nurse practitioners. Payment shall be approved for services provided by advanced registered nurse practitioners within their scope of practice and the limitations of state law, with the exception of services not payable to physicians under rule 441—78.1(249A) or otherwise not payable under any other applicable rule.

78.40(1) *Direct payment.* Payment shall be made to advanced registered nurse practitioners directly, without regard to whether the advanced registered nurse practitioner is employed by or associated with a physician, hospital, birth center, clinic or other health care provider recognized under state law. An established protocol between a physician and the advanced registered nurse practitioner shall not cause an advanced registered nurse practitioner to be considered auxiliary personnel of a physician, or an employee of a hospital, birth center, or clinic.

78.40(2) *Location of service.* Payment shall be approved for services rendered in any location in which the advanced registered nurse practitioner is legally authorized to provide services under state law. The nurse practitioner shall have promptly available the necessary equipment and personnel to handle emergencies.

78.40(3) *Utilization review.* Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.40(4) *Vaccines.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, an advanced registered nurse practitioner must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.40(5) *Prenatal risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

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

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.41(249A) HCBS intellectual disability waiver services. Payment will be approved for the following services to members eligible for the HCBS intellectual disability waiver as established in 441—Chapter 83 and as identified in the member's service plan.

78.41(1) *Supported community living services.* Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. A maximum of four persons may reside in a living unit.

(1) A member may live within the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Maintenance and room and board costs are not reimbursable.

f. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed $1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.41(1)*"f"*(1) does not apply.

g. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.

(2) 20,440 15-minute units are available per state fiscal year except a leap year when 20,496 15-minute units are available.

h. The service shall be identified in the member's service plan.

i. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver.

78.41(2) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be simultaneously reimbursed with other residential, supported community living, nursing, or home health aide services provided through the medical assistance program.

i. Payment for respite services shall not exceed $7,334.62 per the member's waiver year.

78.41(3) *Personal emergency response or portable locator system.*

a. The personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of the system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.41(4) *Home and vehicle modification.* Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.
(11) Special door and window locks.
(12) Specialized doorknobs and handles.
(13) Plexiglas replacement for glass windows.
(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
(15) Motion detectors.
(16) Low-pile carpeting or slip-resistant flooring.
(17) Telecommunications device for the deaf.
(18) Exterior hard-surface pathways.
(19) New door opening.
(20) Pocket doors.
(21) Installation or relocation of controls, outlets, switches.
(22) Air conditioning and air filtering if medically necessary.
(23) Heightening of existing garage door opening to accommodate modified van.
(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.41(5) *Nursing services.* Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the consumer's individual comprehensive plan.

a. A unit of service is one hour.

b. A maximum of ten units are available per week.

78.41(6) *Home health aide services.* Home health aide services are personal or direct care services provided to the member which are not payable under Medicaid as set forth in rule 441—78.9(249A). Services shall include unskilled medical services and shall exceed those services provided under HCBS intellectual disability waiver supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

a. Services shall be included in the member's service plan.

b. A unit is one hour.

c. A maximum of 14 units are available per week.

78.41(7) *Supported employment services.* Supported employment services are service activities provided pursuant to subrule 78.27(10).

78.41(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.41(8)*"f"* and the skilled activities listed in paragraph 78.41(8)*"g."* Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)*"b,"* the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.41(9) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.41(10) *Residential-based supported community living services.* Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

a. Allowable service components are the following:

(1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.

(2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.

(3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.

(4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.

d. Room and board costs are not reimbursable as residential-based supported community living services.

e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.37(23)*"d."*

f. Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.

g. A unit of service is a day.

h. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

78.41(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed simultaneously with HCBS intellectual disability waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

78.41(12) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.41(13) *Prevocational services.* Prevocational services are 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 provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS intellectual disabilities waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Supported community living.
7. Supported employment.
8. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.41(15)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.41(15)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.41(15)*"b"*(3).

(6) Anticipated costs for home and vehicle modification and supported employment services to obtain a job are not subject to the average cost in subparagraph 78.41(15)*"b"*(2) or the utilization adjustment factor in subparagraph 78.41(15)*"b"*(3). Anticipated costs for these services shall not

include the costs of the financial management services or the independent support broker. Costs for home and vehicle modification and supported employment services to obtain a job may be paid to the financial management services provider in a one-time payment. Before becoming part of the individual budget, all home and vehicle modifications and supported employment services to obtain a job shall be identified in the member's service plan and approved by the case manager or service worker.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.41(15)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.

9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.41(15)*"d."* The savings plan shall meet the requirements in paragraph 78.41(15)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7)*"b"* must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7)*"b,"* the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.41(16) *General service standards.* All intellectual disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9650B**, IAB 8/10/11, effective 10/1/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 2050C**, IAB 7/8/15, effective 7/1/15; **ARC 2471C**, IAB 3/30/16, effective 5/4/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16]

441—78.42(249A) Pharmacies administering influenza vaccine to children. Payment will be made to a pharmacy for the administration of influenza vaccine available through the Vaccines for Children (VFC) Program administered by the department of public health if the pharmacy is enrolled in the VFC program. Payment will be made for the vaccine only if the VFC program stock has been depleted.

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

[**ARC 9132B**, IAB 10/6/10, effective 11/1/10; **ARC 9316B**, IAB 12/29/10, effective 2/2/11; **ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.43(249A) HCBS brain injury waiver services. Payment shall be approved for the following services to members eligible for the HCBS brain injury waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

78.43(1) *Case management services.* Individual case management services means services that assist members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. The service shall be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.

c. The case manager must develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers.

d. Members who are eligible for targeted case management are not eligible for case management as a waiver service.

78.43(2) *Supported community living services.* Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. The basic components of the service may include, but are not limited to, personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are those activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service shall provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. Children must first access all other services for which they are eligible and which are appropriate to meet their needs before accessing the HCBS brain injury waiver services. A maximum of four persons may reside in a living unit.

(1) A member may live in the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed $1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.43(2)*"e"*(1) does not apply.

f. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.

(2) 33,580 15-minute units per state fiscal year except a leap year, when 33,672 15-minute units are available.

g. The service shall be identified in the member's service plan.

h. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, transportation, personal assistance, nursing, or home health aide services provided through Medicaid or the HCBS brain injury waiver.

78.43(3) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite care cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, supported community living services, nursing, or home health aide services provided through the medical assistance program.

78.43(4) *Supported employment services.* Supported employment services are service activities provided pursuant to subrule 78.27(10).

78.43(5) *Home and vehicle modification.* Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to $6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.43(6) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.43(7) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

78.43(8) *Specialized medical equipment.*

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a brain injury and which:

(1) Provide for health and safety of the member,

(2) Are not ordinarily covered by Medicaid,

(3) Are not funded by educational or vocational rehabilitation programs, and

(4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

(1) Electronic aids and organizers.

(2) Medicine dispensing devices.

(3) Communication devices.

(4) Bath aids.

(5) Noncovered environmental control units.

(6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to $6,366.64 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.

d. The need for specialized medical equipment shall be:

(1) Documented by a health care professional as necessary for the member's health and safety, and

(2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.43(9) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.43(10) *Family counseling and training services.* Family counseling and training services are face-to-face mental health services provided to the consumer and the family with whom the consumer lives, or who routinely provide care to the consumer to increase the consumer's or family members' capabilities to maintain and care for the consumer in the community. Counseling may include helping the consumer or the consumer's family members with crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects of a brain injury. It may include the use of treatment regimes as specified in the ITP. Periodic training updates may be necessary to safely maintain the consumer in the community.

Family may include spouse, children, friends, or in-laws of the consumer. Family does not include individuals who are employed to care for the consumer.

78.43(11) *Prevocational services.* Prevocational services are service activities provided pursuant to subrule 78.27(9).

78.43(12) *Behavioral programming.* Behavioral programming consists of individually designed strategies to increase the consumer's appropriate behaviors and decrease the consumer's maladaptive behaviors which have interfered with the consumer's ability to remain in the community. Behavioral programming includes:

a. A complete assessment of both appropriate and maladaptive behaviors.

b. Development of a structured behavioral intervention plan which should be identified in the ITP.

c. Implementation of the behavioral intervention plan.

d. Ongoing training and supervision to caregivers and behavioral aides.

e. Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to, clinical redirection, token economies, reinforcement, extinction, modeling, and over-learning.

78.43(13) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.43(13)*"f"* and the skilled activities listed in paragraph 78.43(13)*"g."* Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)*"b,"* the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.43(14) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.43(15) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS brain injury waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Specialized medical equipment.

7. Supported community living.
8. Supported employment.
9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.43(15)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.43(15)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.43(15)*"b"*(3).

(6) Anticipated costs for home and vehicle modification, specialized medical equipment, and supported employment services to obtain a job are not subject to the average cost in subparagraph 78.43(15)*"b"*(2) or the utilization adjustment factor in subparagraph 78.43(15)*"b"*(3). Anticipated costs for these services shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications, specialized medical equipment, and supported employment services to obtain a job shall be identified in the member's service plan and approved by the case manager or service worker. Costs for these services may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.

5. Be the least costly to meet the member's needs.

6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.43(15)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.

2. Clothing not related to an assessed medical need.

3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.

4. Costs associated with shipping items to the member.

5. Experimental and non-FDA-approved medications, therapies, or treatments.

6. Goods or services covered by other Medicaid programs.

7. Home furnishings.

8. Home repairs or home maintenance.

9. Homeopathic treatments.

10. Insurance premiums or copayments.

11. Items purchased on installment payments.

12. Motorized vehicles.

13. Nutritional supplements.

14. Personal entertainment items.

15. Repairs and maintenance of motor vehicles.

16. Room and board, including rent or mortgage payments.

17. School tuition.

18. Service animals.

19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or equipment.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.43(15)*"d."* The savings plan shall meet the requirements in paragraph 78.43(15)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.

2. The amount of the individual budget allocated each month to the savings plan.

3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,

2. Be medically necessary, and

3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7)*"b"* must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7)*"b,"* the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.
(2) Select employees from a worker registry.
(3) Verify employee qualifications.
(4) Specify additional employee qualifications.
(5) Determine employee duties.
(6) Determine employee wages and benefits.
(7) Schedule employees.
(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.43(16) *General service standards.* All brain injury waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 2050C**, IAB 7/8/15, effective 7/1/15; **ARC 2471C**, IAB 3/30/16, effective 5/4/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16]

441—78.44(249A) Lead inspection services. Payment shall be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning, and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

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

441—78.45(249A) Assertive community treatment. Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting.

78.45(1) *Applicability.* ACT services may be provided only to a member who meets all of the following criteria:

a. The member is at least 17 years old.

b. The member has a severe and persistent mental illness or complex mental health symptomatology. A severe and persistent mental illness is a psychiatric disorder that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning (such as social, personal, family, educational or vocational roles). Specifically, the member has a degree of impairment arising from a psychiatric disorder such that:

(1) The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home or community environment without assistance or support;

(2) The member's judgment, impulse control, or cognitive perceptual abilities are compromised; and

(3) The member exhibits significant impairment in social, interpersonal, or familial functioning.

c. The member has a validated principal mental health diagnosis consistent with a severe and persistent mental illness. For this purpose, a mental health diagnosis means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding neurodevelopmental disorders, substance-related disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention. Members with a primary diagnosis of substance-related disorder, developmental disability, or organic disorder are not eligible for ACT services.

d. The member needs a consistent team of professionals and multiple mental health and support services to maintain the member in the community and reduce hospitalizations, as evidenced by:

(1) A pattern of repeated treatment failures with at least two hospitalizations within the previous 24 months, or

(2) A need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

e. The member presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the member's functioning and assist the member in achieving or maintaining community tenure. Specifically, the member:

(1) Is medically stable;

(2) Does not require a level of care that includes more intensive medical monitoring;

(3) Presents a low risk to self, others, or property, with treatment and support; and

(4) Lives independently in the community or demonstrates a capacity to live independently and move from a dependent residential setting to independent living.

f. At the time of admission, the member has a comprehensive assessment that includes psychiatric history, medical history, work and educational history, substance use, problems with activities of daily living, social interests, and family relationships.

g. The member has a written treatment plan containing a work evaluation and the necessary psychiatric rehabilitation treatment and support services. The plan shall identify:

(1) Treatment objectives and outcomes,

(2) The expected frequency and duration of each service,

(3) The location where the services will be provided,

(4) A crisis plan, and

(5) The schedule for updates of the treatment plan.

78.45(2) *Services.* The ACT team shall participate in all mental health services provided to the member and shall provide 24-hour service for the psychiatric needs of the member. Available ACT services are:

a. Evaluation and medication management.

(1) The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the member by a psychiatrist, advanced registered nurse practitioner, or physician assistant.

(2) Medication management consists of the prescription and management of medication by a psychiatrist, advanced registered nurse practitioner, or physician assistant to respond to the member's complaints and symptoms. A psychiatric registered nurse assists in this management by contact with the member regarding medications and their effect on the member's complaints and symptoms.

b. Integrated therapy and counseling for mental health and substance abuse. This service consists of direct counseling for treatment of mental health and substance abuse symptoms by a psychiatrist, licensed mental health professional, advanced registered nurse practitioner, physician assistant, or substance abuse specialist. Individual counseling is provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

c. Skill teaching. Skill teaching consists of side-by-side demonstration and observation of daily living activities by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant.

d. Community support. Community support is provided by a licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant. Community support consists of the following activities focused on recovery and rehabilitation:

(1) Personal and home skills training to assist the member to develop and maintain skills for self-direction and coping with the living situation.

(2) Community skills training to assist the member in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

e. Medication monitoring. Medication monitoring services are provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consist of:

(1) Monitoring the member's day-to-day functioning, medication compliance, and access to medications; and

(2) Ensuring that the member keeps appointments.

f. Case management for treatment and service plan coordination. Case management consists of the development by the ACT team of an individualized treatment and service plan, including personalized goals and outcomes, to address the member's medical symptoms and remedial functional impairments.

(1) Case management includes:

1. Assessments, referrals, follow-up, and monitoring.

2. Assisting the member in gaining access to necessary medical, social, educational, and other services.

3. Assessing the member to determine service needs by collecting relevant historical information through member records and other information from relevant professionals and natural supports.

(2) The team shall:

1. Develop a specific care plan based on the assessment of needs, including goals and actions to address the needed medical, social, educational, and other necessary services.

2. Make referrals to services and related activities to assist the member with the assessed needs.

3. Monitor and perform follow-up activities necessary to ensure that the plan is carried out and that the member has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.

4. Hold daily team meetings to facilitate ACT services and coordinate the member's care with other members of the team.

g. Crisis response. Crisis response consists of direct assessment and treatment of the member's urgent or crisis symptoms in the community by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant, as appropriate.

h. Work-related services. Work-related services may be provided by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant. Services consist of assisting the member in managing mental health symptoms as they relate to job performance. Services may include:

(1) Collaborating with the member to look for job situations that may cause symptoms to increase and creating strategies to manage these situations.

(2) Assisting the member to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.

(3) Providing supports to maintain employment, such as crisis intervention related to employment.

(4) Teaching communication, problem solving, and safety skills.

(5) Teaching personal skills such as time management and appropriate grooming for employment.

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

[**ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 1850C**, IAB 2/4/15, effective 4/1/15; **ARC 2164C**, IAB 9/30/15, effective 10/1/15]

441—78.46(249A) Physical disability waiver service. Payment shall be approved for the following services to members eligible for the HCBS physical disability waiver as established in 441—Chapter 83 and as identified in the member's service plan.

78.46(1) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.46(1)*"f"* and the skilled activities listed in paragraph 78.46(1)*"g."* Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)*"b,"* the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.46(2) *Home and vehicle modification.* Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.
(12) Specialized doorknobs and handles.
(13) Plexiglas replacement for glass windows.
(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
(15) Motion detectors.
(16) Low-pile carpeting or slip-resistant flooring.
(17) Telecommunications device for the deaf.
(18) Exterior hard-surface pathways.
(19) New door opening.
(20) Pocket doors.
(21) Installation or relocation of controls, outlets, switches.
(22) Air conditioning and air filtering if medically necessary.
(23) Heightening of existing garage door opening to accommodate modified van.
(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to $6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

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 provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS physical disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Specialized medical equipment.
4. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.46(6)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment

factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.46(6)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.46(6)*"b"*(3).

(6) Anticipated costs for home and vehicle modification and specialized medical equipment are not subject to the average cost in subparagraph 78.46(6)*"b"*(2) or the utilization adjustment factor in subparagraph 78.46(6)*"b"*(3). Anticipated costs for home and vehicle modification and specialized medical equipment shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification and specialized medical equipment may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual

budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.46(6)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or equipment.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.46(6)*"d."* The savings plan shall meet the requirements in paragraph 78.46(6)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct

services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7)*"b"* must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7)*"b,"* the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for waiver goods and services optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.46(7) *General service standards.* All physical disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 2050C**, IAB 7/8/15, effective 7/1/15; **ARC 2848C**, IAB 12/7/16, effective 11/15/16]

441—78.47(249A) Pharmaceutical case management services. Payment will be approved for pharmaceutical case management services provided by an eligible physician and pharmacist for Medicaid recipients determined to be at high risk for medication-related problems. These services are designed to identify, prevent, and resolve medication-related problems and improve drug therapy outcomes.

78.47(1) *Medicaid recipient eligibility.* Patients are eligible for pharmaceutical case management services if they have active prescriptions for four or more regularly scheduled nontopical medications, are ambulatory, do not reside in a nursing facility, and have at least one of the eligible disease states of congestive heart disease, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux, or chronic obstructive pulmonary disease.

78.47(2) *Provider eligibility.* Physicians and pharmacists shall meet the following criteria to provide pharmaceutical case management services.

a. Physicians and pharmacists must be enrolled in the Iowa Medicaid program, have an Iowa Medicaid provider number, and receive training under the direction of the department regarding the provision of pharmaceutical case management services under the Iowa Medicaid program.

A copy of pharmaceutical case management records, including documentation of services provided, shall be maintained on file in each provider's facility and be made available for audit by the department on request.

b. Physicians shall be licensed to practice medicine.

c. Pharmacists shall present to the department evidence of competency including state licensure, submit five acceptable patient care plans, and have successfully completed professional training on patient-oriented, medication-related problem prevention and resolution. Pharmacists shall also maintain problem-oriented patient records, provide a private patient consultation area, and submit a statement indicating that the submitted patient care plans are representative of the pharmacists' usual patient care plans.

Acceptable professional training programs are:

(1) A doctor of pharmacy degree program.

(2) The Iowa Center for Pharmaceutical Care (ICPC) training program, which is a cooperative training initiative of the University of Iowa College of Pharmacy, Drake University College of Pharmacy and Health Sciences, and the Iowa Pharmacy Foundation.

(3) Other programs containing similar coursework and supplemental practice site evaluation and reengineering, approved by the department with input from a peer review advisory committee.

78.47(3) *Services.* Eligible patients may choose whether to receive the services. If patients elect to receive the services, they must receive the services from any eligible physician and pharmacist acting as a pharmaceutical case management (PCM) team. Usually the eligible physician and pharmacist will be the patient's primary physician and pharmacist. Pharmaceutical case management services are to be value-added services complementary to the basic medical services provided by the primary physician and pharmacist.

The PCM team shall provide the following services:

a. Initial assessment. The initial assessment shall consist of:

(1) A patient evaluation by the pharmacist, including:

1. Medication history;
2. Assessment of indications, effectiveness, safety, and compliance of medication therapy;
3. Assessment for the presence of untreated illness; and
4. Identification of medication-related problems such as unnecessary medication therapy, suboptimal medication selection, inappropriate compliance, adverse drug reactions, and need for additional medication therapy.

(2) A written report and recommendation from the pharmacist to the physician.

(3) A patient care action plan developed by the PCM team with the patient's agreement and implemented by the PCM team. Specific components of the action plan will vary based on patient needs and conditions but may include changes in medication regimen, focused patient or caregiver education, periodic assessment for changes in the patient's condition, periodic monitoring of the effectiveness of medication therapy, self-management training, provision of patient-specific educational and informational materials, compliance enhancement, and reinforcement of healthy lifestyles. An action plan must be completed for each initial assessment.

b. New problem assessments. These assessments are initiated when a new medication-related problem is identified. The action plan is modified and new components are implemented to address the new problem. This assessment may occur in the interim between scheduled follow-up assessments.

c. Problem follow-up assessments. These assessments are based on patient need and a problem identified by a prior assessment. The patient's status is evaluated at an appropriate interval. The effectiveness of the implemented action plan is determined and modifications are made as needed.

d. Preventive follow-up assessments. These assessments occur approximately every six months when no current medication-related problems have been identified in prior assessments. The patient is reassessed for newly developed medication-related problems and the action plan is reviewed.

This rule is intended to implement Iowa Code section 249A.4 and 2000 Iowa Acts, chapter 1228, section 9.

441—78.48(249A) Public health agencies. Payments will be made to local public health agencies on a fee schedule basis for providing vaccine and vaccine administration and testing for communicable disease. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a public health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[**ARC 0358C**, IAB 10/3/12, effective 11/7/12]

441—78.49(249A) Infant and toddler program services. Subject to the following subrules, payment shall be made for medical services provided to Medicaid eligible children by infant and toddler program providers under the infants and toddlers with disabilities program administered by the Iowa Child Health Specialty Clinics and the departments of education, public health, and human services.

78.49(1) *Covered services.* Covered services include, but are not limited to, audiology, psychological evaluation and counseling, health and nursing services, nutrition services, occupational therapy services, physical therapy services, developmental services, speech-language services, vision services, case management, and medical transportation.

78.49(2) *Case management services.* Payment shall also be approved for infant and toddler case management services subject to the following requirements:

a. Definition. "Case management" means services that will assist eligible children in gaining access to needed medical, social, educational, and other services. Case management is intended to address the complexities of coordinated service delivery for children with medical needs. The case manager should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need. Case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible child has been referred or any activities that are an integral part or an extension of the direct services.

b. Choice of provider. Children who also are eligible to receive targeted case management services under 441—Chapter 90 must choose whether to receive case management through the infant and toddler program or through 441—Chapter 90. The chosen provider must meet the requirements of this subrule.

(1) When a child resides in a medical institution, the institution is responsible for case management. The child is not eligible for any other case management services. However, noninstitutional case management services may be provided during the last 14 days before the child's planned discharge if the child's stay in the institution has been less than 180 consecutive days. If the child has been in the institution 180 consecutive days or longer, the child may receive noninstitutional case management services during the last 60 days before the child's planned discharge.

(2) If the case management agency also provides direct services, the case management unit must be designed so that conflict of interest is addressed and does not result in self-referrals.

(3) If the costs of any part of case management services are reimbursable under another program, the costs must be allocated between those programs and Medicaid in accordance with OMB Circular No. A-87 or any related or successor guidance or regulations regarding allocation of costs.

(4) The case manager must complete a competency-based training program with content related to knowledge and understanding of eligible children, Early ACCESS rules, the nature and scope of services in Early ACCESS, and the system of payments for services, as well as case management responsibilities and strategies. The department of education or its designee shall determine whether a person has successfully completed the training.

c. Assessment. The case manager shall conduct a comprehensive assessment and periodic reassessment of an eligible child to identify all of the child's service needs, including the need for

any medical, educational, social, or other services. Assessment activities are defined to include the following:

(1) Taking the child's history;

(2) Identifying the needs of the child;

(3) Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the child;

(4) Completing documentation of the information gathered and the assessment results; and

(5) Repeating the assessment every six months to determine whether the child's needs or preferences have changed.

d. Plan of care. The case manager shall develop a plan of care based on the information collected through the assessment or reassessment. The plan of care shall:

(1) Include the child's strengths and preferences;

(2) Consider the child's physical and social environment;

(3) Specify goals of providing services to the child; and

(4) Specify actions to address the child's medical, social, educational, and other service needs. These actions may include activities such as ensuring the active participation of the child and working with the child or the child's authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the child.

e. Other service components. Case management must include the following components:

(1) Contacts with the child and family. The case manager shall have face-to-face contact with the child and family within the first 30 days of service and every three months thereafter. In months in which there is no face-to-face contact, a telephone contact between the service coordinator and the family is required.

(2) Referral and related activities to help a child obtain needed services. The case manager shall help to link the child with medical, social, or educational providers or other programs and services that are capable of providing needed services. Referral activities do not include provision of the direct services, program, or activity to which the child has been linked. Referral activities include:

1. Assisting the family in gaining access to the infant and toddler program services and other services identified in the child's plan of care.

2. Assisting the family in identifying available service providers and funding resources and documenting unmet needs and gaps in services.

3. Making referrals to providers for needed services.

4. Scheduling appointments for the child.

5. Facilitating the timely delivery of services.

6. Arranging payment for medical transportation.

(3) Monitoring and follow-up activities. Monitoring activities shall take place at least once annually for the duration of the child's eligibility, but may be conducted as frequently as necessary to ensure that the plan of care is effectively implemented and adequately addresses the needs of the child. Monitoring and follow-up activities may be with the child, family members, providers, or other entities. The purpose of these activities is to help determine:

1. Whether services are being furnished in accordance with the child's plan of care.

2. Whether the services in the plan of care are adequate to meet the needs of the child.

3. Whether there are changes in the needs or status of the child. If there are changes in the child's needs or status, follow-up activities shall include making necessary adjustments to the plan of care and to service arrangements with providers.

(4) Keeping records, including preparing reports, updating the plan of care, making notes about plan activities in the child's record, and preparing and responding to correspondence with the family and others.

f. Documentation of case management. For each child receiving case management, case records must document:

(1) The name of the child;

(2) The dates of case management services;

(3) The agency chosen by the family to provide the case management services;
(4) The nature, content, and units of case management services received;
(5) Whether the goals specified in the care plan have been achieved;
(6) Whether the family has declined services in the care plan;
(7) Time lines for providing services and reassessment; and
(8) The need for and occurrences of coordination with case managers of other programs.

78.49(3) *Child's eligibility.* Payable services must be provided to a child under the age of 36 months who is experiencing developmental delay or who has a condition that is known to have a high probability of resulting in developmental delay at a later date.

78.49(4) *Delivery of services.* Services must be delivered directly by the infant and toddler program provider or by a practitioner under contract with the infant and toddler program provider.

78.49(5) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

a. Rescinded IAB 5/10/06, effective 7/1/06.

b. The infant and toddler program provider has executed an agreement to remit the nonfederal share of the cost to the department.

c. The infant and toddler program provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services specified on the form.

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

441—78.50(249A) Local education agency services. Subject to the following subrules, payment shall be made for medical services provided by local education agency services providers to Medicaid members under the age of 21.

78.50(1) *Covered services.* Covered services include, but are not limited to, audiology services, behavior services, consultation services, medical transportation, nursing services, nutrition services, occupational therapy services, personal assistance, physical therapy services, psychologist services, speech-language services, social work services, vision services, and school-based clinic visit services.

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

b. Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed $25 per month. Durable medical equipment and other supplies are not covered as local education agency services.

c. To the extent that federal funding is not available under Title XIX of the Social Security Act, payment for transportation between home and school is not a covered service.

78.50(2) *Coordination services.* Rescinded IAB 12/3/08, effective 2/1/09.

78.50(3) *Delivery of services.* Services must be delivered directly by the local education agency services providers or by a practitioner under contract with the local education agency services provider.

78.50(4) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

a. Rescinded IAB 5/10/06, effective 7/1/06.

b. The local education agency services provider has executed an agreement to remit the nonfederal share of the cost to the department.

c. The local education agency provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services as specified on the form.

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

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.51(249A) Indian health service 638 facility services. Payment shall be made for all medically necessary services and supplies provided by a licensed practitioner at an Indian health service

638 facility, as defined at rule 441—77.45(249A), within the practitioner's scope of practice and subject to the limitations and exclusions set forth in subrule 78.1(1).

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

441—78.52(249A) HCBS children's mental health waiver services. Payment will be approved for the following services to members eligible for the HCBS children's mental health waiver as established in 441—Chapter 83 and as identified in the member's service plan.

78.52(1) *General service standards.* All children's mental health waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

78.52(2) *Environmental modifications and adaptive devices.*

a. Environmental modifications and adaptive devices include medically necessary items installed or used within the member's home that are used by the member to address specific, documented health, mental health, or safety concerns. The following items are excluded under this service:

(1) Items ordinarily covered by Medicaid.

(2) Items funded by educational or vocational rehabilitation programs.

(3) Items provided by voluntary means.

(4) Repair and maintenance of items purchased through the waiver.

(5) Fencing.

b. A unit of service is one modification or device.

c. For each unit of service provided, the case manager shall maintain in the member's case file a signed statement from a mental health professional on the member's interdisciplinary team that the service has a direct relationship to the member's diagnosis of serious emotional disturbance.

d. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.52(3) *Family and community support services.* Family and community support services shall support the member and the member's family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the member's and the family's social and emotional strength.

a. Dependent on the needs of the member and the member's family members individually or collectively, family and community support services may be provided to the member, to the member's family members, or to the member and the family members as a family unit.

b. Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the member's interdisciplinary team pursuant to 441—Chapter 83.

c. Family and community support services shall incorporate recommended support interventions and activities, which may include the following:

(1) Developing and maintaining a crisis support network for the member and for the member's family.

(2) Modeling and coaching effective coping strategies for the member's family members.

(3) Building resilience to the stigma of serious emotional disturbance for the member and the family.

(4) Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.

(5) Modeling and coaching the strategies and interventions identified in the member's crisis intervention plan as defined in 441—24.1(225C) for life situations with the member's family and in the community.

(6) Developing medication management skills.

(7) Developing personal hygiene and grooming skills that contribute to the member's positive self-image.

(8) Developing positive socialization and citizenship skills.

d. Family and community support services may include an amount not to exceed $1500 per member per year for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

(1) The interdisciplinary team must have identified the transportation or therapeutic resource as a support need and included that need in the case manager's plan.

(2) The annual amount available for transportation and therapeutic resources must be listed in the member's service plan.

(3) The member's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the member or the member's family or legal guardian.

(4) The member's Medicaid case manager shall maintain a signed statement that potential community resources are unavailable and shall list the community resources contacted to fund the transportation or therapeutic resource.

(5) The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

e. The following components are specifically excluded from family and community support services:

(1) Vocational services.

(2) Prevocational services.

(3) Supported employment services.

(4) Room and board.

(5) Academic services.

(6) General supervision and care.

f. A unit of family and community support services is 15 minutes.

78.52(4) *In-home family therapy.* In-home family therapy provides skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment.

a. The goal of in-home family therapy is to maintain a cohesive family unit.

b. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through the Iowa Plan or other funding sources.

c. A unit of in-home family therapy service is 15 minutes.

78.52(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Respite services provided outside the member's home shall not be reimbursable if the living unit where respite care is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more members who require nursing care because of a mental or physical condition must be provided by a health care facility licensed under Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[**ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13]

441—78.53(249A) Health home services. Subject to federal approval in the Medicaid state plan, payment shall be made for health home services as described in subrule 78.53(1) provided to an eligible Medicaid member as described in subrule 78.53(2) who has selected a health home services provider as provided in subrule 78.53(3).

78.53(1) *Covered services.* Health home services consist of the following services provided in a comprehensive, timely, and high-quality manner using health information technology to link services, as feasible and appropriate:

a. Comprehensive care management, which means:

(1) Providing for all the member's health care needs or taking responsibility for arranging care with other qualified professionals;

(2) Developing and maintaining for each member a continuity of care document that details all important aspects of the member's medical needs, treatment plan, and medication list; and

(3) Implementing a formal screening tool to assess behavioral health treatment needs and physical health care needs.

b. Care coordination, which means assisting members with:

(1) Medication adherence;

(2) Chronic disease management;

(3) Appointments, referral scheduling, and reminders; and

(4) Understanding health insurance coverage.

c. Health promotion, which means coordinating or providing behavior modification interventions aimed at:

(1) Supporting health management;

(2) Improving disease control; and

(3) Enhancing safety, disease prevention, and an overall healthy lifestyle.

d. Comprehensive transitional care following a member's move from an inpatient setting to another setting. Comprehensive transitional care includes:

(1) Updates of the member's continuity of care document and case plan to reflect the member's short-term and long-term care coordination needs; and

(2) Personal follow-up with the member regarding all needed follow-up after the transition.

e. Member and family support (including authorized representatives). This support may include:

(1) Communicating with and advocating for the member or family for the assessment of care decisions;

(2) Assisting with obtaining and adhering to medications and other prescribed treatments;

(3) Increasing health literacy and self-management skills; and

(4) Assessing the member's physical and social environment so that the plan of care incorporates needs, strengths, preferences, and risk factors.

f. Referral to community and social support services available in the community.

78.53(2) *Members eligible for health home services.*

a. Subject to the authority of the Secretary of the United States Department of Health and Human Services pursuant to 42 U.S.C. §1396w-4(h)(1)(B) to establish higher levels for the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services, payment shall be made only for health home services provided to a Medicaid member who:

(1) Has at least two chronic conditions;

(2) Has one chronic condition and is at risk of having a second chronic condition;

(3) Has a serious mental illness; or

(4) Has a serious emotional disturbance.

b. For purposes of this rule, the term "chronic condition" means:

(1) A mental health disorder.

(2) A substance use disorder.

(3) Asthma.

(4) Diabetes.

(5) Heart disease.

(6) Being overweight, as evidenced by:

1. Having a body mass index (BMI) over 25 for an adult, or

2. Weighing over the 85th percentile for the pediatric population.

(7) Hypertension.

c. For purposes of this rule, the term "serious mental illness" means:

(1) A psychotic disorder;

(2) Schizophrenia;

(3) Schizoaffective disorder;

(4) Major depression;

(5) Bipolar disorder;

(6) Delusional disorder; or

(7) Obsessive-compulsive disorder.

d. For purposes of this rule, the term "serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder (not including substance use disorders, learning disorders, or intellectual disorders) that is of sufficient duration to meet diagnostic criteria specified in the most current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and that results in a functional impairment. For this purpose, the term "functional impairment" means episodic, recurrent, or continuous difficulties that substantially interfere with or limit a person from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills and that substantially interfere with or limit the person's role or functioning in family, school, or community activities, not including difficulties resulting from temporary and expected responses to stressful events in a person's environment.

78.53(3) *Selection of health home services provider.* As a condition of payment for health home services, the eligible member receiving the services must have selected the billing provider as the member's health home, as reported by the provider. A member must select a provider located in the member's county of residence or in a contiguous county.

This rule is intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.

[**ARC 0198C**, IAB 7/11/12, effective 7/1/12; **ARC 0838C**, IAB 7/24/13, effective 7/1/13]

441—78.54(249A) Speech-language pathology services. Payment will be approved for the same services provided by a speech-language pathologist that are payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2158.
[**ARC 0360C**, IAB 10/3/12, effective 12/1/12]

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).

g. Quality review. The IME medical services unit may perform the quality review to evaluate:

(1) The time elapsed from referral to rehabilitation treatment plan development;

(2) The continuity of treatment;

(3) The length of stay per member;

(4) The affiliation of the medical professional recommending services with the neurobehavioral rehabilitation services provider;

(5) Gaps in service;

(6) The results achieved;

(7) Member and stakeholder satisfaction;

(8) The provider's compliance with standards listed in rule 441—77.54(249A).

78.56(4) *Medical necessity.* Nothing in this rule shall be deemed to exempt coverage of community-based neurobehavioral rehabilitation services from the requirement that services be medically necessary. "Medically necessary" means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition;

b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

c. The least costly type of service that can reasonably meet the medical needs of the member; and

d. In accordance with the standards of good medical practice. The standards of good practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of good practice identified by:

(1) Knowledgeable Iowa clinicians practicing or teaching in the field; and

(2) The professional literature regarding best practices in the field.

78.56(5) *Documentation standards.* Community-based neurobehavioral rehabilitation service providers shall maintain service provision records, financial records, and clinical records in accordance with the provisions of rule 441—79.3(249A).

[**ARC 2341C**, IAB 1/6/16, effective 2/10/16]

441—78.57(249A) Child care medical services. Payments will be made to licensed child care centers that provide medical services in addition to child care. Medically necessary services are provided under a plan of care that is developed by licensed professionals within their scope of practice and authorized by the member's physician. The services include and implement a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, personal care, psychosocial and developmental therapies required by the medically dependent or technologically dependent child served.

78.57(1) Nursing services are services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in a licensed child care center. Nursing services shall be provided according to a written plan of care authorized by a physician.

Payment for nursing services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Nursing services include activities that require the expertise of a nurse, such as physical assessment, tracheostomy care, medication administration, and tube feedings.

78.57(2) Personal care services are those services which are provided by an aide but are delegated and supervised by a registered nurse under the direction of the member's physician. Payment for personal care services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Personal care services shall be in accordance with the member's plan of care and authorized by a physician. Personal care services include the activities of daily living, oral hygiene, grooming, toileting, feeding, range of motion and positioning, and training the member in necessary self-help skills, including teaching prosocial skills and reinforcing positive interactions.

78.57(3) Psychosocial services are those services that focus at decreasing or eliminating maladaptive behaviors. Payment for psychosocial services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Psychosocial services shall be in accordance with the member's plan of care and authorized by a physician. Psychosocial services include implementing a plan using clinically accepted techniques for decreasing or eliminating maladaptive behaviors. Psychosocial intervention plans must be developed and reviewed by licensed mental health providers.

78.57(4) Developmental therapies are those services which are provided by an aide but are delegated and supervised by a licensed therapist under the direction of the member's physician. Payment for developmental therapies may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Developmental therapies shall be in accordance with the member's plan of care and authorized by a physician. Developmental therapies include activities based on the individual's needs such as fine motor, gross motor, and receptive expressive language.

78.57(5) "Medically necessary" means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, or threaten to cause or aggravate a disability or chronic illness and is an effective course of treatment for the member requesting a service.

78.57(6) Requirements.

a. Nursing, psychosocial, developmental therapies and personal care services shall be ordered in writing.

b. Nursing, psychosocial, developmental therapies and personal care services shall be authorized by the department or the department's designated review agent prior to payment.

c. Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. A treatment plan shall be completed prior to the start of care and at a minimum reviewed every 180 days thereafter. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

(1) Place of service.
(2) Type of service to be rendered and the treatment modalities being used.
(3) Frequency of the services.
(4) Assistance devices to be used.
(5) Date on which services were initiated.
(6) Progress of member in response to treatment.
(7) Medical supplies to be furnished.
(8) Member's medical condition as reflected by the following information, if applicable:

1. Dates of prior hospitalization.
2. Dates of prior surgery.
3. Date last seen by a primary care provider.
4. Diagnoses and dates of onset of diagnoses for which treatment is being rendered.

5. Prognosis.
6. Functional limitations.
7. Vital signs reading.
8. Date of last episode of acute recurrence of illness or symptoms.
9. Medications.

(9) Discipline of the person providing the service.

(10) Certification period.

(11) Physician's signature and date. The treatment plan must be signed and dated by the physician before the claim for service is submitted for reimbursement.

(12) Forms 470-4815 and 470-4816 are utilized during the prior authorization review.

78.57(7) Nursing, personal care, and psychosocial services do not include:

a. Services provided to members aged 21 and older.

b. Services that require prior authorizations that are provided without regard to the prior authorization process.

c. Nursing services provided simultaneously with other Medicaid services (e.g., home health aide, physical, occupational, or speech therapy services, etc.).

d. Services that exceed the services that are approvable under the private duty nursing and personal care program pursuant to subrule 78.9(10).

e. Transportation services.

f. Services provided to a member while the member is in institutional care.

This rule is intended to implement Iowa Code chapter 249A.

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◊ Two or more ARCs

1 Effective date of 78.3 and 78.31 delayed 70 days by the Administrative Rules Review Committee at its January 1, 1988 meeting.

2 Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting.

3 Effective date of 4/1/91 delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its meeting held February 12, 1991.

4 Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

5 At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

6 Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.

7 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.

8 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.

CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 79]

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

For purposes of this chapter, "managed care organization" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

79.1(1) *Types of reimbursement.*

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

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

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

(1) The actual charge made by the provider of service.

(2) The maximum allowance under the fee schedule for the item of service in question.

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

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

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

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

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

(2) Payments are subject to annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider on Form 470-0664, Financial and Statistical Report. The cost settlement represents the difference between the amount received by the provider during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost appointment.

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

1. The indirect administrative costs shall be limited to 23 percent of other costs. Other costs include: professional staff – direct salaries, other – direct salaries, benefits and payroll taxes associated with direct salaries, mileage and automobile rental, agency vehicle expense, automobile insurance, and other related transportation.

2. Mileage shall be reimbursed at a rate no greater than the state employee rate.

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

4. Costs of operation shall include only those costs that pertain to the provision of services which are authorized under rule 441—90.3(249A).

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

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

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

(3) The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on the provider's actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 4.5 percent.

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

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

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

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

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

Provider category	Basis of reimbursement	Upper limit
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 6/30/14 plus 10%. Air ambulance: Fee schedule in effect 6/30/14 plus 10%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 6/30/13 plus 1%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Assertive community treatment	Fee schedule	$51.08 per day for each day on which a team meeting is held. Maximum of 5 days per week.
Audiologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Behavioral health intervention	Fee schedule	Fee schedule in effect 7/1/13.
Behavioral health services	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Birth centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Child care medical services	Fee schedule	Fee schedule in effect 1/1/16.
Chiropractors	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community-based neurobehavioral rehabilitation services	Fee schedule, see 79.1(28)	Residential: Limit in effect as of June 30 each year plus CPI-U for the preceding 12-month period ending June 30. Intermittent: $21.11 per 15-minute unit.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Dentists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Drug and alcohol services	Fee schedule	Fee schedule in effect 1/1/16.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/13 plus 1%.
Emergency psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Family planning clinics	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.

Provider category	Basis of reimbursement	Upper limit
Federally qualified health centers	Retrospective cost-related. See 441—Chapter 73	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
HCBS waiver service providers, including:		Except as noted, limits apply to all waivers that cover the named provider.
1. Adult day care	Fee schedule	Effective 7/1/16, for AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/16 rate: Veterans Administration contract rate or $1.47 per 15-minute unit, $23.47 per half day, $46.72 per full day, or $70.06 per extended day if no Veterans Administration contract. Effective 7/1/16, for intellectual disability waiver: County contract rate or, in the absence of a contract rate, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/16 rate, $1.96 per 15-minute unit, $31.27 per half day, $70.06 per full day, or $79.59 per extended day.
2. Emergency response system:		
Personal response system	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: Initial one-time fee: $52.04. Ongoing monthly fee: $40.47.
Portable locator system	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: One equipment purchase: $323.26. Initial one-time fee: $52.04. Ongoing monthly fee: $40.47.

Provider category	Basis of reimbursement	Upper limit
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and health and disability waivers effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1% or maximum Medicaid rate in effect 6/30/16 plus 1%. For intellectual disability waiver effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1% or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to an hourly rate.
4. Homemakers	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $5.20 per 15-minute unit.
5. Nursing care	For elderly and intellectual disability waivers: Fee schedule as determined by Medicare.	For elderly waiver effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: $87.99 per visit. For intellectual disability waiver effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1% or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to an hourly rate.
	For AIDS/HIV and health and disability waivers: Agency's financial and statistical cost report and Medicare percentage rate per visit.	For AIDS/HIV and health and disability waivers effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: $87.99 per visit.
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, not to exceed $315.09 per day.

Provider category	Basis of reimbursement	Upper limit
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, not to exceed $315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $3.49 per 15-minute unit, not to exceed $315.09 per day.
Home care agency:		
Specialized respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $8.96 per 15-minute unit, not to exceed $315.09 per day.
Basic individual respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $4.78 per 15-minute unit, not to exceed $315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $3.49 per 15-minute unit, not to exceed $315.09 per day.
Nonfacility care:		
Specialized respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $8.96 per 15-minute unit, not to exceed $315.09 per day.
Basic individual respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $4.78 per 15-minute unit, not to exceed $315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $3.49 per 15-minute unit, not to exceed $315.09 per day.

Provider category	Basis of reimbursement	Upper limit
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $3.49 per 15-minute unit, not to exceed the facility's daily Medicaid rate for skilled nursing level of care.
Nursing facility	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $3.49 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Camps	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $3.49 per 15-minute unit, not to exceed $315.09 per day.
Adult day care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $3.49 per 15-minute unit, not to exceed rate for regular adult day care services.
Intermediate care facility for persons with an intellectual disability	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $3.49 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Residential care facilities for persons with an intellectual disability	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $3.49 per 15-minute unit, not to exceed contractual daily rate.
Foster group care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $3.49 per 15-minute unit, not to exceed daily rate for child welfare services.
Child care facilities	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $3.49 per 15-minute unit, not to exceed contractual daily rate.

Provider category	Basis of reimbursement	Upper limit
7. Chore service	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: $4.05 per 15-minute unit.
8. Home-delivered meals	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: $8.10 per meal. Maximum of 14 meals per week.
9. Home and vehicle modification	Fee schedule. See 79.1(17)	For elderly waiver effective 7/1/13: $1,061.11 lifetime maximum. For intellectual disability waiver effective 7/1/13: $5,305.53 lifetime maximum. For brain injury, health and disability, and physical disability waivers effective 7/1/13: $6,366.64 per year.
10. Mental health outreach providers	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: On-site Medicaid reimbursement rate for center or provider. Maximum of 1,440 units per year.
11. Transportation	Fee schedule	Effective 10/1/13: The provider's nonemergency medical transportation contract rate or, in the absence of a nonemergency medical transportation contract rate, the median nonemergency medical transportation contract rate paid per mile or per trip within the member's DHS region.
12. Nutritional counseling	Fee schedule	Effective 7/1/16 for non-county contract: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $8.76 per 15-minute unit.
13. Assistive devices	Fee schedule. See 79.1(17)	Effective 7/1/13: $115.62 per unit.
14. Senior companion	Fee schedule	Effective 7/1/16 for non-county contract: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $1.89 per 15-minute unit.
15. Consumer-directed attendant care provided by:		

Provider category	Basis of reimbursement	Upper limit
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $5.35 per 15-minute unit, not to exceed $123.85 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $5.35 per 15-minute unit, not to exceed $123.85 per day.
Individual	Fee agreed upon by member and provider	Effective 7/1/16, $3.58 per 15-minute unit, not to exceed $83.36 per day. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7)*"b,"* the payment rate must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.
16. Counseling:		
Individual	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $11.45 per 15-minute unit.
Group	Fee schedule	Effective 7/1/6, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $11.44 per 15-minute unit. Rate is divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.
17. Case management	Fee for service with cost settlement. See 79.1(1)*"d."*	For brain injury and elderly waivers: Retrospective cost-settled rate.
18. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	For intellectual disability and brain injury waiver effective 7/1/16: $9.28 per 15-minute unit, not to exceed the maximum daily ICF/ID rate per day plus 3.927%.
19. Supported employment:		
Individual supported employment	Fee schedule	Fee schedule in effect 7/1/16. Total monthly cost for all supported employment services not to exceed $3,059.29 per month.

Provider category	Basis of reimbursement	Upper limit
Long-term job coaching	Fee schedule	Fee schedule in effect 7/1/16. Total monthly cost for all supported employment services not to exceed $3,059.29 per month.
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect 7/1/16. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed $3,059.29 per month.
20. Specialized medical equipment	Fee schedule. See 79.1(17)	Effective 7/1/13, $6,366.64 per year.
21. Behavioral programming	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: $11.45 per 15 minutes.
22. Family counseling and training	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $11.44 per 15-minute unit.
23. Prevocational services, including career exploration	Fee schedule	Fee schedule in effect 7/1/16.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate.
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate.
Child development home or center	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $3.49 per 15-minute unit.
Supported community living provider	Retrospectively limited prospective rate. See 79.1(15)	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $9.28 per 15-minute unit, not to exceed the maximum ICF/ID rate per day plus 3.927%.
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/16: Not to exceed the maximum ICF/ID rate per day plus 3.927%.

Provider category	Basis of reimbursement	Upper limit
26. Day habilitation	Fee schedule	Effective 7/1/16: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute or daily rate. If no 6/30/16 rate: $3.51 per 15-minute unit or $68.23 per day.
27. Environmental modifications and adaptive devices	Fee schedule. See 79.1(17)	Effective 7/1/13, $6,366.64 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $9.28 per 15-minute unit.
29. In-home family therapy	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $24.85 per 15-minute unit.
30. Financial management services	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: $68.97 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: $16.07 per hour.
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7)*"b,"* the payment rate must be based on 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.
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7)*"b,"* the payment rate must be based on 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.

Provider category	Basis of reimbursement	Upper limit
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7)*"b,"* the payment rate must be based on 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.
35. Assisted living on-call service providers (elderly waiver only)	Fee agreed upon by member and provider.	$26.08 per day.
Health home services provider	Fee schedule based on the member's qualifying health condition(s).	Monthly fee schedule amount.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Home- and community-based habilitation services:		
1. Case management	See 79.1(24)*"d"*	Retrospective cost-settled rate.
2. Home-based habilitation	See 79.1(24)*"d"*	Effective 7/1/13: $11.68 per 15-minute unit, not to exceed $6,083 per month, or $200 per day.
3. Day habilitation	See 79.1(24)*"d"*	Effective 7/1/13: $3.30 per 15-minute unit or $64.29 per day.
4. Prevocational habilitation Career exploration	Fee schedule	Fee schedule in effect May 4, 2016.
5. Supported employment:		
Individual supported employment	Fee schedule	Fee schedule in effect May 4, 2016. Total monthly cost for all supported employment services not to exceed $3,029.00 per month.
Long-term job coaching	Fee schedule	Fee schedule in effect May 4, 2016. Total monthly cost for all supported employment services not to exceed $3,029.00 per month.
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect May 4, 2016. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed $3,029.00 per month.

Provider category	Basis of reimbursement	Upper limit
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, and medical social services; home health care for maternity patients and children	Fee schedule. See 79.1(26). For members living in a nursing facility, see 441—paragraph 81.6(11)*"r."*	Effective 7/1/16: Medicare LUPA rates in effect on 6/30/16 plus a 2.93% increase.
2. Private-duty nursing and personal cares for members aged 20 or under	Retrospective cost-related. See 79.1(27)	Effective 7/1/13: Actual and allowable cost not to exceed a maximum of 133% of statewide average.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14)*"d"*)
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1)*"g"* and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 6/30/13 plus 1%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16)*"c"*	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 6/30/13 plus 1%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health service 638 facilities	1. Base rate as determined by the United States Office of Management and Budget for outpatient visits for American Indian and Alaskan native members.	1. Office of Management and Budget rate published in the Federal Register for outpatient visit rate.
	2. Fee schedule for service provided for all other Medicaid members.	2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for persons with an intellectual disability	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Local education agency services providers	Fee schedule	Fee schedule.
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 6/30/13 plus 1%.

Provider category	Basis of reimbursement	Upper limit
Nursing facilities: 1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(1)"1" and (2)"1" is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(1)"2" and (2)"2" is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16)*"f."* The direct care rate component limit under 441—81.6(16)*"f"*(1) and (2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)*"f"*(1) and (2) is 110% of the patient-day-weighted median.

Provider category	Basis of reimbursement	Upper limit
2. Hospital-based, Medicare-certified nursing care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(3)"1" is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(3)"2" is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See subrules 441—81.6(4) and 81.6(14) and paragraph 81.6(16)*"f."* The direct care rate component limit under 441—81.6(16)*"f"*(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)*"f"*(3) is 110% of the patient-day-weighted median.
Occupational therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)*"r."*	Fee schedule in effect 6/30/13 plus 1%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).
Pharmacy administration of influenza vaccine to children	Physician fee schedule for immunization administration	Fee schedule in effect 6/30/13 plus 1%.
Physical therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)*"r."*	Fee schedule in effect 6/30/13 plus 1%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)*"a"*	Fee schedule in effect 6/30/13 plus 1%.
Anesthesia services	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Physician-administered drugs	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Qualified primary care services	See 79.1(7)*"c"*	Rate provided by 79.1(7)*"c"*

Provider category	Basis of reimbursement	Upper limit
Podiatrists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Prescribed drugs	See 79.1(8)	Amount pursuant to 79.1(8).
Psychiatric medical institutions for children:		
1. Inpatient in non-state-owned facilities	Fee schedule	Effective 7/1/14: non-state-owned facilities provider-specific fee schedule in effect.
2. Inpatient in state-owned facilities	Retrospective cost-related	Effective 8/1/11: 100% of actual and allowable cost.
3. Outpatient day treatment	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Psychologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Public health agencies	Fee schedule	Fee schedule rate in effect 6/30/13 plus 1%.
Rehabilitation agencies	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)*"r."*	Medicaid fee schedule in effect 6/30/13 plus 1%; refer to 79.1(21).
Remedial services	Retrospective cost-related. See 79.1(23)	110% of average cost less 5%.
Rural health clinics	Retrospective cost-related. See 441—Chapter 73	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
Screening centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Speech-language pathologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
State-operated institutions	Retrospective cost-related	
Targeted case management providers	Fee for service with cost settlement. See 79.1(1)*"d."*	Retrospective cost-settled rate.

79.1(3) *Ambulatory surgical centers.*

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

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

79.1(4) *Durable medical equipment, prosthetic devices, medical supply dealers.* Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment shall be the lowest price for which the devices are widely and consistently available in a locality. Reimbursement over an established Medicaid fee schedule amount may be allowed pursuant to the criteria at 441—paragraph 78.10(5)*"n."*

79.1(5) *Reimbursement for hospitals.*

a. Definitions.

"Adolescent" shall mean a Medicaid patient 17 years or younger.

"Adult" shall mean a Medicaid patient 18 years or older.

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

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

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

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

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

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

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

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

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

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

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

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and
2. Is a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions for dates of service on or after October 1, 2014.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"GME/DSH fund implementation year" means 2009.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Rebasing implementation year" means 2008 and every three years thereafter.

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

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

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

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

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

(2) Neonatal intensive care units certified pursuant to 79.1(5)*"r."* Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating

neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization. The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

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

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

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

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

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

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

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

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

1. The total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and
2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services rendered on or after October 1, 2006, and indirect medical education.

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

(2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base-year cost report or MMIS claims system, the actual dollar expenditures for capital costs,

direct medical education costs, and the payments made for nonfull DRG transfers, outliers, physical rehabilitation services, and psychiatric services rendered on or after October 1, 2006, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

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

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

e. Add-ons to the base amount.

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

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

Allowable capital costs are determined by multiplying the capital amount from the base-year cost report by 80 percent. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

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

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

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

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

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

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

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

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

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

g. Billing for patient transfers and readmissions.

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

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

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

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

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

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

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

(5) Inpatient readmissions within 30 days for same condition. Effective for dates of service on or after July 1, 2015, when an inpatient is discharged or transferred from an acute care hospital and is readmitted as an inpatient to the same hospital within 30 days for the same condition, any claim for the subsequent inpatient stay shall be combined with the claim for the original inpatient stay and payment shall be under a single DRG for both stays.

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

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

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

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

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

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

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

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

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

k. Inflation factors, rebasing, and recalibration.

(1) Inflation factors shall be set annually at levels that ensure payments that are consistent with efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care

and services are available at least to the extent that such care and services are available to the general population in the geographic area.

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

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

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

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

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

m. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year will receive a case-mix-adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

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

(2) Hospitals that qualify for disproportionate share payment based on the definition established by their state's Medicaid agency for the calculation of the Medicaid inpatient utilization rate will be eligible to receive disproportionate share payments according to paragraph 79.1(5)*"y,"* for dates of service prior to October 1, 2014. Out-of-state hospitals do not qualify for disproportionate share payments for dates of service on or after October 1, 2014.

(3) Out-of-state hospitals do not qualify for direct medical education or indirect medical education payments pursuant to paragraph 79.1(5)*"y."*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report. The department's total year-end disproportionate share obligation shall not exceed the difference between the following:

1. The annual amount appropriated to the IowaCare account for distribution to publicly owned acute care teaching hospitals located in a county with a population over 350,000; and

2. The actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid enterprise to qualifying hospitals.

w. Rate adjustments for hospital mergers. When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new entity.

Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

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

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

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

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services is $7,594,294.03. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

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

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

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

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

(4) Qualifying for indirect medical education. Iowa hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size. Out-of-state hospitals do not qualify for indirect medical education payments.

(5) Allocation to fund for indirect medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services is $13,450,285.14. If a hospital fails to qualify for indirect medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

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

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

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

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

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

1. For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

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

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

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

5. Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services

to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

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

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

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

(8) Allocation to fund for disproportionate share. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments is $6,959,868.59. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

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

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

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

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

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

(10) Qualifying for disproportionate share as a children's hospital. A licensed hospital qualifies for disproportionate share payments as a children's hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age. In addition, the hospital must be a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions for dates of service on or after October 1, 2014.

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

1. Base year cost reports.

2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. Final settlement for state-owned teaching hospital.

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

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

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

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

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

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

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

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

ab. Nonpayment for preventable conditions. Preventable conditions identified pursuant to this rule that develop during inpatient hospital treatment shall not be considered in determining reimbursement for such treatment.

(1) Coding. All diagnoses included on an inpatient hospital claim must include one of the following codes indicating whether the condition was present or developing at the time of the order for inpatient admission:

Present on Admission (POA) Indicator Codes

Code	Explanation
Y	The condition was present or developing at the time of the order for inpatient admission.
N	The condition was not present or developing at the time of the order for inpatient admission.
U	Documentation is insufficient to determine whether the condition was present or developing at the time of the order for inpatient admission.
W	Clinically undetermined. The provider is clinically unable to determine whether or not the condition was present or developing at the time of the order for inpatient admission.

(2) Payment processing. Claims will be processed according to the DRG methodology without consideration of any diagnosis identified by the Secretary of the United States Department of Health and Human Services pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)) if the condition was not present or developing at the time of the order for inpatient admission.

ac. Rural hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)*"y,"* payment shall be made to qualifying Iowa hospitals that elect to participate in rural hospital disproportionate share payments. Interim monthly payments will be made based on the amount of state share that is transferred to the department.

(1) Qualifying criteria. A hospital that qualifies for disproportionate share payments pursuant to paragraph 79.1(5)*"y"* and that is a rural prospective payment hospital not designated as a critical access hospital qualifies for rural hospital disproportionate share payments.

(2) Source of nonfederal share. The required nonfederal share shall be funds generated from tax levy collections of the county or city in which the hospital is located, and is subject to the conditions specified in this subparagraph and applicable federal law and regulations.

1. The nonfederal share funds shall be distributed to the department prior to the issuance of any disproportionate share payment to a qualifying hospital.

2. The city or county providing the nonfederal share funds shall annually document and certify that the funds provided as the nonfederal share were generated from tax proceeds, and not from any other source including federal grants or another federal funding source.

3. The applicable federal matching rate for the fiscal year shall apply.

(3) Amount of payment. The total amount of disproportionate share payments made pursuant to paragraph 79.1(5)*"y"* and the rural hospital disproportionate share payments shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. Qualifying hospitals shall annually provide a disproportionate share hospital survey within the time frames specified by the department, for the purpose of calculating the hospital-specific disproportionate share limits under Public Law 103-666.

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

79.1(7) *Physicians.*

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

b. Payment reduction for services rendered in facility settings. Rescinded IAB 10/30/13, effective 1/1/14.

c. Payment for primary care services. To the extent required by 42 U.S.C. § 1396a(a)(13)(C), primary care services furnished in calendar year 2013 or 2014 by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to subparagraphs (1) to (4) and (6) of this paragraph (79.1(7)*"c"*). Primary care services furnished on or after January 1, 2015, by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to subparagraphs (1) to (3), (5), and (7) of this paragraph (79.1(7)*"c"*).

(1) Primary care services eligible for payment pursuant to this paragraph (79.1(7)*"c"*) include:

1. Evaluation and management (E & M) services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 99201 through 99499, or their successor codes; and

2. Vaccine administration services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 90460, 90461, 90471, 90472, 90473 and 90474, or their successor codes.

(2) For purposes of this paragraph (79.1(7)*"c"*), a qualified primary care physician is a physician who:

1. Is certified by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA) with a specialty designation of family medicine, general internal medicine, or pediatric medicine or with a subspecialty designation recognized by the certifying organization as a subspecialty of family medicine, general internal medicine, or pediatric medicine; or

2. Has furnished primary care services eligible for payment pursuant to this paragraph (79.1(7)*"c"*) equal to at least 60 percent of the Iowa Medicaid services for which the qualified primary care physician has submitted claims during the most recently completed calendar year or, for newly eligible physicians, the prior month (excluding claims not paid and claims for which Medicare is the primary payer).

(3) For payment to be made under this paragraph (79.1(7)*"c"*), the qualified primary care physician must have certified that the physician is a qualified primary care physician by submitting Form 470-5138, Iowa Medicaid Primary Care Physician Certification and Attestation for Primary Care Rate Increase, prior to the date of service or by April 1, 2013, for services rendered January 1, 2013, through April 1, 2013.

(4) Primary care services rendered in calendar year 2013 or 2014. Primary care services rendered in calendar year 2013 or 2014 that are eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

2. The applicable rate under Medicare Part B, in effect for services rendered on the first day of the calendar year;

3. The rate that would be applicable under Medicare Part B, in effect for services rendered on the first day of the calendar year, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or

4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(a)(1).

(5) Primary care services rendered on or after January 1, 2015. Primary care services rendered on or after January 1, 2015, that are eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

2. The applicable rate under Medicare Part B in effect for services rendered on January 1, 2014;

3. The rate that would be applicable under Medicare Part B, in effect for services rendered on January 1, 2014, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or

4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(a)(1), and in effect on June 30, 2014.

(6) Notwithstanding the foregoing provisions of this paragraph (79.1(7)*"c"*), payment for the administration of vaccines provided under the Vaccines for Children Program in calendar year 2013 or 2014 shall be limited to the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program; or

2. The applicable Medicare fee schedule rate for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

(7) Notwithstanding the foregoing provisions of this paragraph (79.1(7)*"c"*), payment for the administration of vaccines provided under the Vaccines for Children Program on or after January 1, 2015, shall be the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program in effect on June 30, 2014; or

2. The applicable Medicare fee schedule rate in effect on June 30, 2014, for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 rate that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

79.1(8) *Drugs.* The amount of payment shall be based on several factors, subject to the upper limits in 42 CFR 447.500 to 447.520 as amended to May 16, 2012. The Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic.

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

(1) The average actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)*"g,"* plus the professional dispensing fee determined pursuant to paragraph 79.1(8)*"f."*

(2) The maximum allowable cost (MAC), defined as the specific upper limit for multiple source drugs established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee determined pursuant to paragraph 79.1(8)*"f."*

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

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

(1) The average actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)*"g,"* plus the professional dispensing fee determined pursuant to paragraph 79.1(8)*"f."*

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

c. No payment shall be made for sales tax.

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

e. An additional reimbursement amount of one cent per dose shall be added to the allowable cost of a prescription pursuant to paragraphs 79.1(8)*"a"* and *"b"* for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist.

f. The professional dispensing fee shall be a fee schedule amount determined by the department based on a survey of Iowa Medicaid participating pharmacy providers' costs of dispensing drugs to Medicaid beneficiaries conducted every two years beginning in SFY 2014-2015.

g. For purposes of this rule, average actual acquisition cost (AAC) is defined as retail pharmacies' average prices paid to acquire drug products. Average AAC shall be determined by the department based on a survey of invoice prices paid by Iowa Medicaid retail pharmacies. Surveys shall be conducted at least once every six months, or more often at the department's discretion. The average AAC shall be calculated as a statistical mean based on one reported cost per drug per pharmacy. The average AAC determined by the department shall be published on the Iowa Medicaid enterprise Web site. If no current average AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span shall be used as the average AAC.

h. Payment to physicians for physician-administered drugs billed with healthcare common procedure coding system (HCPCS) Level II "J" codes, as a physician service, shall be pursuant to physician payment policy under subrule 79.1(2).

79.1(9) *HCBS consumer choices financial management.*

a. Monthly allocation. A financial management service provider shall receive a monthly fee as established in subrule 79.1(2) for each consumer electing to work with that provider

under the HCBS consumer choices option. The financial management service provider shall also receive monthly the consumer's individual budget amount as determined under 441—paragraph 78.34(13)*"b,"*78.37(16)*"b,"*78.38(9)*"b,"*78.41(15)*"b,"*78.43(15)*"b,"* or 78.46(6)*"b."*

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

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

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

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

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

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

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

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

79.1(10) *Prohibition against reassignment of claims.* No payment under the medical assistance program for any care or service provided to a patient by any health care provider shall be made to anyone other than the providers. However with respect to physicians, dentists or other individual practitioners direct payment may be made to the employer of the practitioner if the practitioner is required as a condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to a foundation, plan or similar organization including a health maintenance organization which furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person's services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, which renders statements and receives payment in the name of the provider when the agent's compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule shall preclude making payment to the estate of a deceased practitioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d. The member shall pay $3 copayment for:

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

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

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

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

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

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

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

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

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

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

(2) Serious impairment to bodily functions, or

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

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

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

n. The member shall pay a $3 copayment for each visit to a hospital emergency room for treatment that does not meet the criteria for an emergency service as defined in paragraph 79.1(13)*"k."* This $3 copayment shall not apply if the visit to the emergency room results in a hospital admission.

79.1(14) *Reimbursement for hospice services.*

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

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

(1) Routine home care.

(2) Continuous home care.

(3) Inpatient respite care.

(4) General inpatient care.

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

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

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

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

d. Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year. The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price

Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

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

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

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

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

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.
2. Multiplying excess inpatient care days by the routine home care rate.
3. Adding together the amounts calculated in "1" and "2."
4. Comparing the amount in "3" with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement shall be refunded by the hospice.

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

79.1(15) *HCBS retrospectively limited prospective rates.* This methodology applies to reimbursement for HCBS supported community living; HCBS family and community support services; and HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency.

a. Reporting requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(9) The reasonable costs of direct care staff training shall be treated as direct care costs, rather than as indirect administrative costs.

c. Prospective rates for new providers.

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

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

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

d. Prospective rates for established providers.

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

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

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

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

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

e. Prospective rates for respite. Rescinded IAB 5/1/13, effective 7/1/13.

f. Retrospective adjustments.

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

(2) For services provided from July 1, 2015, through June 30, 2016, revenues exceeding adjusted actual costs by more than 4.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(3) For services provided from July 1, 2015, through June 30, 2016, providers who do not reimburse revenues exceeding 104.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 104.5 percent of the actual costs deducted from future payments.

(4) For services provided on or after July 1, 2016, revenues exceeding adjusted actual costs by more than 5.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(5) For services provided on or after July 1, 2016, providers who do not reimburse revenues exceeding 105.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 105.5 percent of the actual costs deducted from future payments.

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

79.1(16) *Outpatient reimbursement for hospitals.*

a. Definitions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"GME/DSH fund implementation year" means 2009.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital's financial and statistical report.

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

c. Payment for outpatient hospital services.

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

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

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

(3) The APC payment is calculated as follows:

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

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

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

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

Indicator	Item, Code, or Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as: ● Ambulance services. ● Clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy. ● Erythropoietin for end-stage renal dialysis (ESRD) patients. ● Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital.	For services covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* For services not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).
B	Codes that are not paid by Medicare on an outpatient hospital basis	Not paid under OPPS APC. ● May be paid when submitted on a different bill type other than outpatient hospital (13x). ● An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E	Items, codes, and services: ● That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or ● For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid.	If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.

Indicator	Item, Code, or Service	OPPS Payment Status
F	Certified registered nurse anesthetist services Corneal tissue acquisition Hepatitis B vaccines	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
K	Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: ● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. ● Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c"* when either no APC or APC weight is established. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
L	Influenza vaccine Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.

Indicator	Item, Code, or Service	OPPS Payment Status
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q1	STVX-packaged codes	Paid under OPPS APC. ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "S," "T," "V," or "X." ● In all other circumstances, payment is made through a separate APC payment.
Q2	T-packaged codes	Paid under OPPS APC. ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "T." ● In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	If covered by Iowa Medicaid, the code is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the code is not paid under OPPS APC or any other Medicaid payment system.
R	Blood and blood products	If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
S	Significant procedure, not discounted when multiple	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
T	Significant procedure, multiple reduction applies	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
U	Brachytherapy sources	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.

Indicator	Item, Code, or Service	OPPS Payment Status
V	Clinic or emergency department visit	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment, subject to limits on nonemergency services provided in an emergency room pursuant to 79.1(16)*"r."* If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.
X	Ancillary services	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.
Y	Nonimplantable durable medical equipment	For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).

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

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

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

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

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

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

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

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

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

3. The total calculated Medicaid cost for ambulance services.

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

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

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

f. Calculation of statewide base APC rate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

j. Rebasing.

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

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

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

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

k. Payment to out-of-state hospitals. Out-of-state hospitals providing care to members of Iowa's Medicaid program shall be reimbursed in the same manner as Iowa hospitals, except as provided in subparagraphs (1) and (2).

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

(2) Out-of-state hospitals do not qualify for direct medical education payments pursuant to paragraph 79.1(16)*"v."*

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

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

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

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

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

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

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

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

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

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

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

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

r. Services delivered in the emergency room. Payment to a hospital for assessment of any Medicaid member in an emergency room shall be made pursuant to fee schedule. Payment for treatment of a Medicaid member in an emergency room shall be made as follows:

(1) If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided.

(2) If the emergency room visit does not result in an inpatient hospital admission but involves emergency services as defined in paragraph 79.1(13)*"k,"* payment for treatment provided in the emergency room shall be made at the full APC payment for the treatment provided.

(3) If the emergency room visit does not result in an inpatient hospital admission and does not involve emergency services as defined in paragraph 79.1(13)*"k,"* payment for treatment provided in the emergency room depends on whether the member had a referral to the emergency room.

1. For members who were referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 75 percent of the APC payment for the treatment provided.

2. For members who were not referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 50 percent of the APC payment for the treatment provided.

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

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

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

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

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total annual state fiscal year funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is $2,766,718.25. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

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

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

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

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

w. Final settlement for state-owned teaching hospital.

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

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus

2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus

3. $9,900,000.

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

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

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

79.1(17) *Reimbursement for home- and community-based services home and vehicle modification and equipment.* Payment is made for home and vehicle modifications, assistive devices, specialized medical equipment, and environmental modifications and adaptive devices at the amount authorized by the department through a quotation, contract, or invoice submitted by the provider.

a. The case manager shall submit the service plan and the contract, invoice or quotations from the providers to the Iowa Medicaid enterprise for prior approval before the modification is initiated or the equipment is purchased. Payment shall not be approved for duplicate items.

b. Whenever possible, three itemized bids for the modification or quotations for equipment purchase shall be presented for review. The amount payable shall be based on the least expensive item that meets the member's medical needs.

c. Payment for most items shall be based on a fee schedule and shall conform to the limitations set forth in subrule 79.1(12).

(1) For services and items that are furnished under Part B of Medicare, the fee shall be the lowest charge allowed under Medicare.

(2) For services and items that are furnished only under Medicaid, the fee shall be the lowest charge determined by the department according to the Medicare reimbursement method described in Section 1834(a) of the Social Security Act (42 U.S.C. 1395m), Payment for Durable Medical Equipment.

(3) Payment for supplies with no established Medicare fee shall be at the average wholesale price for the item less 10 percent.

(4) Payment for items with no Medicare fee, Medicaid fee, or average wholesale price shall be made at the manufacturer's suggested retail price less 15 percent.

(5) Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price shall be made at the dealer's cost plus 10 percent. The actual invoice for the item from the manufacturer must be submitted with the claim. Catalog pages or printouts supplied by the provider are not considered invoices.

(6) For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment shall be the lowest price for which such devices are widely and consistently available in a locality.

(7) Payment for used equipment shall not exceed 80 percent of the purchase allowance.

(8) No allowance shall be made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies.

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

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

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

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

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

79.1(20) *Dentists.* The dental fee schedule is based on the definitions of dental and surgical procedures given in the current version of the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association.

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

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

a. Definitions. For purposes of this subrule:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

79.1(24) *Reimbursement for home- and community-based habilitation services.* Reimbursement for case management, job development, and employer development services provided prior to July 1, 2013, is based on a fee schedule developed using the methodology described in paragraph 79.1(1)*"d."* Reimbursement for home-based habilitation, day habilitation, prevocational habilitation, enhanced job search and supports to maintain employment services provided prior to July 1, 2013, is based on a retrospective cost-related rate calculated using the methodology in paragraphs 79.1(24)*"b"* and *"c."* Reimbursement for all home- and community-based habilitation services provided on or after July 1, 2013, shall be as provided in paragraph 79.1(24)*"d."* All rates are subject to the upper limits established in subrule 79.1(2).

a. Units of service.

(1) A unit of case management is 15 minutes.

(2) A unit of home-based habilitation is a 15-minute unit (for up to 31 units per day) or one day (for 8 or more hours per day), based on the average hours of service provided during a 24-hour period as an average over a calendar month. Reimbursement for services shall not exceed the upper limit for daily home-based habilitation services set in 79.1(2).

1. The daily unit of service shall be used when a member receives services for 8 or more hours provided during a 24-hour period as an average over a calendar month. The 15-minute unit shall be used when the member receives services for 1 to 31 15-minute units provided during a 24-hour period as an average over a calendar month.

2. The member's comprehensive service plan must identify and reflect the need for the amount of supervision and skills training requested. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.

(3) A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).

(4) A unit of supported employment habilitation supports to maintain employment is a 15-minute unit.

b. Submission of cost reports. For services provided prior to July 1, 2013, the department shall determine reasonable and proper costs of operation for home-based habilitation, day habilitation, prevocational habilitation, and supported employment based on cost reports submitted by the provider on Form 470-4425, Financial and Statistical Report for HCBS Habilitation Services.

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

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

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

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

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

(6) If a provider fails to submit a cost report for services provided through June 30, 2013, that meets the requirements of this paragraph, the Iowa Medicaid enterprise or the Iowa Plan for Behavioral Health contractor shall reduce the provider's rate to 76 percent of the current rate. The reduced rate shall be paid until the provider's cost report has been received by the Iowa Medicaid enterprise's provider cost audit and rate setting unit pursuant to subparagraph 79.1(24)*"b"*(4) but for not longer than three months, after which time no further payments will be made.

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

c. Rate determination based on cost reports. For services provided prior to July 1, 2013, reimbursement shall be made using a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation.

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

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

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

d. Reimbursement for services provided on or after July 1, 2013.

(1) For dates of services July 1, 2013, through December 31, 2013, providers shall be reimbursed by the Iowa Plan for Behavioral Health contractor at the fee schedule or interim rate for the service and the provider in effect on June 30, 2013, with no retrospective adjustment or cost settlement. However, if a provider fails to submit a cost report for services provided prior to July 1, 2013, that meets the requirements of paragraph 79.1(24)*"b,"* the Iowa Plan for Behavioral Health contractor shall reduce the provider's reimbursement rate to 76 percent of the rate in effect on June 30, 2013. The reduced rate shall be paid until acceptable cost reports for all services provided prior to July 1, 2013, have been received.

(2) For dates of services from January 1, 2014, through December 31, 2015, providers shall be reimbursed by the Iowa Plan for Behavioral Health contractor at the rate negotiated by the provider and the contractor. However, if a provider fails to submit a cost report for services provided prior to July 1, 2013, that meets the requirements of paragraph 79.1(24)*"b,"* the Iowa Plan for Behavioral Health contractor shall reduce the provider's reimbursement rate to 76 percent of the negotiated rate. The reduced rate shall be paid until acceptable cost reports for all services provided prior to July 1, 2013, have been received.

(3) For dates of services on or after January 1, 2016, providers shall be reimbursed by fee schedule.

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

a. Reimbursement methodology for providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3). Effective for services rendered on or after October 1, 2006, providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) that provide clinic services are paid on a reasonable-cost basis as determined by Medicare reimbursement principles.

b. Reimbursement methodology for community mental health centers. Effective for services rendered on or after July 1, 2014, community mental health centers may elect to be paid on either a 100 percent of reasonable costs basis, as determined by Medicare reimbursement principles, or in accordance with an alternative reimbursement rate methodology approved by the department of human services. Once a community mental health center chooses the alternative reimbursement rate methodology, the community mental health center may not change its elected reimbursement methodology to 100 percent of reasonable costs.

c. Cost-based reimbursement. For providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) and CMHCs that elect the 100 percent of reasonable costs basis of reimbursement, rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report, pursuant to the following.

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

1. The statewide fee schedule for community mental health centers effective July 1, 2006, or

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

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

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

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

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

d. Reporting requirements. All providers other than CMHCs that have elected the alternative reimbursement rate methodology established by the Medicaid program's managed care contractor for mental health services shall submit cost reports using Form 470-4419, Financial and Statistical Report. Hospital-based providers required to submit a cost report shall also submit the Medicare cost report, CMS Form 2552-96. The following requirements apply to all required cost reports.

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

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

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

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

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

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

79.1(26) *Home health services.*

a. Services included under the home health services program are reimbursed on the low utilization payment amount (LUPA) methodology, with state geographic adjustments.

b. Medicare LUPA per-visit rates in effect on July 1, 2013, are the basis for establishing the LUPA methodology for the initial reimbursement schedule.

c. Medicare LUPA per-visit rates shall be increased July 1 every two years to reflect the most recent Medicare LUPA rates.

d. Home health services subject to this methodology are skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services provided by Medicare-certified home health agencies.

79.1(27) *Reimbursement for early periodic screening, diagnosis, and treatment private duty nursing and personal cares program.*

a. Rate determination based on cost reports. Reimbursement shall be made using an hourly rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation not to exceed the upper limit as provided in subrule 79.1(2).

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated 15-minute and hourly rate. Pending determination of private duty nursing and personal cares program costs, the provider may bill for and shall be reimbursed at an hourly rate that the provider and the Iowa Medicaid enterprise (IME) may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review or audit or both by the Iowa Medicaid enterprise to determine the actual cost of services in accordance with generally accepted accounting principles, Medicare cost principles published in Centers for Medicare and Medicaid Services Publication §15-1, and the Office of Management and Budget Circular A-87, Attachment B, subject to the exceptions and limitations in the department's administrative rules.

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

b. Financial and statistical report submission and reporting requirements.

(1) The provider shall submit the complete Financial and Statistical Report, Form 1728-94, in an electronic format approved by the department to the IME provider cost audit and rate setting unit within five months of the end of the provider's fiscal year.

(2) The submission of the financial and statistical report must include a working trial balance that corresponds to the data contained on the financial and statistical report and the Medicare cost report. Financial and statistical reports submitted without a working trial balance and the Medicare cost report will be considered incomplete.

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

(4) Providers shall submit a completed financial and statistical report to the IME provider cost audit and rate setting unit in an electronic format that can be opened using the extensionxls orxlsx. The supplemental documentation shall be submitted in a generally accepted business format. The report and required supplemental information shall be e-mailed to costaudit@dhs.state.ia.us on or before the last day of the fifth month after the end of the provider's fiscal year. One signed copy of the certification page of the Medicaid and Medicare cost reports shall be mailed to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, no later than the due date of the required electronic submissions.

(5) If a provider fails to submit a cost report that meets the requirement of subparagraph 79.1(27)*"b"*(4), the department shall reduce payment to 75 percent of the current rate(s).

1. The reduced rate(s) shall be effective the first day of the sixth month following the provider's fiscal year end and shall remain in effect until the first day of the month after the delinquent report is received by the IME provider cost audit and rate setting unit.

2. The reduced rate(s) shall be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by the IME provider cost audit and rate setting unit.

(6) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting and provide documentation detailing these adjustments. Failure to maintain records to support the cost report may result in the following, but not limited to:

1. Recoupment of Medicaid payments.
2. Penalties.
3. Sanctions pursuant to rule 441—79.3(249A).

(7) The department, in its sole discretion, may on its own initiative reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or to submit an amended financial and statistical report for review by the department, after the provider is notified of its reimbursement rates following review of a financial and statistical report.

(8) A projected cost report shall be submitted when a home health agency enters the program or adds private duty nursing and the personal cares program. Prospective interim rates shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new program is added.

(9) A provider of services under multiple programs shall submit a cost allocation schedule that was used during the preparation of the financial and statistical report.

(10) Costs reported under private duty nursing and the personal cares program shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under private duty nursing and the personal cares program.

(11) When a provider continues to include as an item of cost an item or items which had in a prior period been removed by an adjustment by the department or its contractor, in the total program costs, the contractor shall recommend to the department that the reimbursement rates be reduced to 75 percent of the current reimbursement rate for the entire quarter beginning the first day of the sixth month after the provider's fiscal year end. The department may, after considering the seriousness of the exception, make the reduction.

(12) Nothing in this subrule relieves a provider of its obligation to immediately inform the department that it has retained Medicaid funds to which it is not entitled as a result of any cost report process. A provider must notify the Iowa Medicaid enterprise when the provider notes that funds are incorrectly paid or when an overpayment has been detected.

c. Terminated home health agencies.

(1) A participating home health agency contemplating termination of private duty nursing and the personal cares program shall provide the department of human services with at least 60 days' prior notice. The person responsible for the termination is responsible for submission of a final financial and statistical report through the date of the termination. The final home health cost report shall meet the reporting requirements in paragraph 79.1(27)*"b."*

(2) For facilities that terminate activity with the Iowa Medicaid enterprise, a financial and statistical report from the beginning of the fiscal year to the date of termination will be required, regardless if termination is voluntary, involuntary or due to a change in ownership. All documentation in paragraph 79.1(27)*"a"* shall be submitted 45 days after the date of termination, by the terminated (closed) entity. If no report is received within 45 days, the Iowa Medicaid enterprise will begin the process to recoup all funds for dates of service beginning from the last filed cost report to the date of termination.

79.1(28) *Reimbursement for community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services.*

a. New providers. Providers who are newly enrolled shall be paid prospective rates based on projected reasonable and proper costs of operation based on the statewide average rate paid to community-based neurobehavioral rehabilitation service providers in effect June 30 each fiscal year.

b. Established providers. After establishment of the initial rate for a provider, the rate will be adjusted annually, effective July 1 each year. The provider's new rate shall be the previously established

rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, not to exceed the limit in effect June 30.

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

[**ARC 7835B**, IAB 6/3/09, effective 7/8/09; **ARC 7937B**, IAB 7/1/09, effective 7/1/09; **ARC 7957B**, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); **ARC 8205B**, IAB 10/7/09, effective 11/11/09; **ARC 8206B**, IAB 10/7/09, effective 11/11/09; **ARC 8344B**, IAB 12/2/09, effective 12/1/09; **ARC 8643B**, IAB 4/7/10, effective 3/11/10; **ARC 8647B**, IAB 4/7/10, effective 3/11/10; **ARC 8649B**, IAB 4/7/10, effective 3/11/10; **ARC 8894B**, IAB 6/30/10, effective 7/1/10; **ARC 8899B**, IAB 6/30/10, effective 7/1/10; **ARC 9046B**, IAB 9/8/10, effective 8/12/10; **ARC 9127B**, IAB 10/6/10, effective 11/10/10; **ARC 9134B**, IAB 10/6/10, effective 10/1/10; **ARC 9132B**, IAB 10/6/10, effective 11/1/10; **ARC 9176B**, IAB 11/3/10, effective 12/8/10; **ARC 9316B**, IAB 12/29/10, effective 2/2/11; **ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 9588B**, IAB 6/29/11, effective 9/1/11; **ARC 9706B**, IAB 9/7/11, effective 8/17/11; **ARC 9708B**, IAB 9/7/11, effective 8/17/11; **ARC 9710B**, IAB 9/7/11, effective 8/17/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9712B**, IAB 9/7/11, effective 9/1/11; **ARC 9714B**, IAB 9/7/11, effective 9/1/11; **ARC 9719B**, IAB 9/7/11, effective 9/1/11; **ARC 9722B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 9886B**, IAB 11/30/11, effective 1/4/12; **ARC 9887B**, IAB 11/30/11, effective 1/4/12; **ARC 9958B**, IAB 1/11/12, effective 2/15/12; **ARC 9959B**, IAB 1/11/12, effective 2/15/12; **ARC 9960B**, IAB 1/11/12, effective 2/15/12; **ARC 9996B**, IAB 2/8/12, effective 1/19/12; **ARC 0028C**, IAB 3/7/12, effective 4/11/12; **ARC 0029C**, IAB 3/7/12, effective 4/11/12; **ARC 9959B** nullified (See nullification note at end of chapter); **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0194C**, IAB 7/11/12, effective 7/1/12; **ARC 0196C**, IAB 7/11/12, effective 7/1/12; **ARC 0198C**, IAB 7/11/12, effective 7/1/12; **ARC 0358C**, IAB 10/3/12, effective 11/7/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0355C**, IAB 10/3/12, effective 12/1/12; **ARC 0354C**, IAB 10/3/12, effective 12/1/12; **ARC 0360C**, IAB 10/3/12, effective 12/1/12; **ARC 0485C**, IAB 12/12/12, effective 2/1/13; **ARC 0545C**, IAB 1/9/13, effective 3/1/13; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0581C**, IAB 2/6/13, effective 4/1/13; **ARC 0585C**, IAB 2/6/13, effective 1/9/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0708C**, IAB 5/1/13, effective 7/1/13; **ARC 0710C**, IAB 5/1/13, effective 7/1/13; **ARC 0713C**, IAB 5/1/13, effective 7/1/13; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 0823C**, IAB 7/10/13, effective 9/1/13; **ARC 0838C**, IAB 7/24/13, effective 7/1/13; **ARC 0840C**, IAB 7/24/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 0848C**, IAB 7/24/13, effective 7/1/13; **ARC 0864C**, IAB 7/24/13, effective 7/1/13; **ARC 0994C**, IAB 9/4/13, effective 11/1/13; **ARC 1051C**, IAB 10/2/13, effective 11/6/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1057C**, IAB 10/2/13, effective 11/6/13; **ARC 1058C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1150C**, IAB 10/30/13, effective 1/1/14; **ARC 1152C**, IAB 10/30/13, effective 1/1/14; **ARC 1154C**, IAB 10/30/13, effective 1/1/14; **ARC 1481C**, IAB 6/11/14, effective 8/1/14; **ARC 1519C**, IAB 7/9/14, effective 7/1/14; **ARC 1521C**, IAB 7/9/14, effective 7/1/14; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 1608C**, IAB 9/3/14, effective 10/8/14; **ARC 1609C**, IAB 9/3/14, effective 10/8/14; **ARC 1699C**, IAB 10/29/14, effective 1/1/15; **ARC 1697C**, IAB 10/29/14, effective 1/1/15; **ARC 1977C**, IAB 4/29/15, effective 7/1/15; **ARC 2026C**, IAB 6/10/15, effective 8/1/15; **ARC 2075C**, IAB 8/5/15, effective 7/15/15; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2167C**, IAB 9/30/15, effective 11/4/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 2341C**, IAB 1/6/16, effective 2/10/16; **ARC 2471C**, IAB 3/30/16, effective 5/4/16; **ARC 2846C**, IAB 12/7/16, effective 11/15/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16]

441—79.2(249A) Sanctions.

79.2(1) *Definitions.*

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

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

"Person" means any individual human being or any company, firm, association, corporation, institution, or other legal entity. "Person" includes but is not limited to a provider and any affiliate of a provider.

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

"Provider" means an individual human being, firm, corporation, association, institution, or other legal entity, which is providing or has been approved to provide medical assistance to a member pursuant to the state medical assistance program.

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

"Suspension of payments" means the temporary cessation of payments due a person until the resolution of a matter in dispute between a person and the department.

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

"Withholding of payments" means a reduction or adjustment of the amounts paid to a person on pending and subsequently submitted bills for purposes of offsetting payments made to, received by, or in the possession of a person.

79.2(2) *Grounds for sanctions.* The department may impose sanctions against any person when appropriate. Appropriate grounds for the department to impose sanctions include, but are not limited to, the following:

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

b. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of obtaining greater compensation than that to which the person is legally entitled, including charges in excess of usual and customary charges.

c. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of meeting prior authorization or level of care requirements.

d. Upon lawful demand, failing to disclose or make available to the department, the department's authorized agent, any law enforcement or peace officer, any agent of the department of inspections and appeals' Medicaid fraud control unit, any agent of the auditor of state, the Iowa department of justice, any false claims investigator as defined under Iowa Code chapter 685, or any other duly authorized federal or state agent or agency records of services provided to medical assistance members or records of payments made for those services.

e. Failing to provide or maintain quality services, or a requisite assurance of a framework of quality services to medical assistance recipients within accepted medical community standards as adjudged by professional peers if applicable. For purposes of this subrule, "quality services" means services provided in accordance with the applicable rules and regulations governing the services.

f. Engaging in a course of conduct or performing an act which is in violation of any federal, state, or local statute, rule, regulation, or ordinance, or an applicable contractual provision, that relates to, or arises out of, any publicly or privately funded health care program, including but not limited to any state medical assistance program.

g. Submitting a false, intentionally misleading, or fraudulent certification or statement, whether the certification or statement is explicit or implied, to the department or the department's representative or to any other publicly or privately funded health care program.

h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing a member to receive services or merchandise not required or requested.

i. Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto, or violating any federal or state false claims Act, including but not limited to Iowa Code chapter 685.

j. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information in an application for provider status under the medical assistance program or any quality review or other submission required to maintain good standing in the program.

k. Violating any law, regulation, or code of ethics governing the conduct of an occupation, profession, or other regulated business activity, when the violation relates to, or arises out of, the delivery of services under the state medical assistance program.

l. Breaching any settlement or similar agreement with the department, or failing to abide by the terms of any agreement with any other entity relating to, or arising out of, the state medical assistance program.

m. Failing to meet standards required by state or federal law for participation, including but not limited to licensure.

n. Exclusion from Medicare or any other state or federally funded medical assistance program.

o. Except as authorized by law, charging a person for covered services over and above what the department paid or would pay or soliciting, offering, or receiving a kickback, bribe, or rebate, or accepting or rebating a fee or a charge for medical assistance or patient referral, or a portion thereof. This ground does not include the collection of a copayment or deductible if otherwise allowed by law.

p. Failing to correct a deficiency in provider operations after receiving notice of the deficiency from the department or other federal or state agency.

q. Formal reprimand or censure by an association of the provider's peers or similar entity related to professional conduct.

r. Suspension or termination for cause from participation in another program, including but not limited to workers' compensation or any publicly or privately funded health care program.

s. Indictment or other institution of criminal charges for, or plea of guilty or nolo contendere to, or conviction of, any crime punishable by a term of imprisonment greater than one year, any crime of violence, any controlled substance offense, or any crime involving an allegation of dishonesty or negligent practice resulting in death or injury to a provider's patient.

t. Violation of a condition of probation, suspension of payments, or other sanction.

u. Loss, restriction, or lack of hospital privileges for cause.

v. Negligent, reckless, or intentional endangerment of the health, welfare, or safety of a person.

w. Billing for services provided by an excluded, nonenrolled, terminated, suspended, or otherwise ineligible provider or person.

x. Failing to submit a self-assessment, corrective action plan, or other requirement for continued participation in the medical assistance program, or failing to repay an overpayment of medical assistance funds, in a timely manner, as set forth in a rule or other order.

y. Attempting, aiding or abetting, conspiring, or knowingly advising or encouraging another person in the commission of one or more of the grounds specified herein.

79.2(3) *Sanctions.*

a. The department may impose any of the following sanctions on any person:

(1) A term of probation for participation in the medical assistance program.

(2) Termination from participation in the medical assistance program.

(3) Suspension from participation in the medical assistance program.

(4) Suspension of payments in whole or in part.

(5) Prior authorization of services.

(6) Review of claims prior to payment.

b. The withholding of a payment or a recoupment of medical assistance funds is not, in itself, a sanction. Overpayments, civil monetary penalties, and interest may also be withheld from payments without imposition of a sanction.

c. Mandatory suspensions and terminations.

(1) Suspension or termination from participation in the medical assistance program is mandatory when a person is suspended or terminated from participation in the Medicare program, another state's medical assistance program, or by any licensing body. The suspension or termination from participation in the medical assistance program shall be retroactive to the date established by the Centers for Medicare and Medicaid Services or other state or body and, in the case of a suspension, must continue until at least such time as the Medicare or other state's or body's suspension ends.

(2) Termination is mandatory upon entry of final judgment, in the Iowa district court or a federal district court of the United States, of liability of the person in a false claims action.

(3) Suspension from participation is mandatory whenever a person, or an affiliate of the person, has an outstanding overpayment of medical assistance funds, as defined in Iowa Code chapter 249A.

(4) Upon notification from the U.S. Department of Justice, the Iowa department of justice, the department of inspections and appeals, or a similar agency, that a person has failed to respond to a civil investigative demand or other subpoena in a timely manner as set forth in governing law and the demand or other subpoena itself, the department shall immediately suspend the person from participation and suspend all payments to the person. The suspension and payment suspension shall end upon notification that the person has responded to the demand in full.

79.2(4) *Imposition and extent of sanction.* The department shall consider the totality of the circumstances in determining the sanctions to be imposed. The factors the department may consider include, but are not limited to:

a. Seriousness of the offense.

b. Extent of violations.

c. History of prior violations.

d. Prior imposition of sanctions.

e. Prior provision of provider education (technical assistance).

f. Provider willingness to obey program rules.

g. Whether a lesser sanction will be sufficient to remedy the problem.

h. Actions taken or recommended by peer review groups or licensing boards.

79.2(5) *Scope of sanction.*

a. Suspension or termination from participation shall preclude the person from submitting claims for payment, whether personally or through claims submitted by any other person or affiliate, for any services or supplies except for those services provided before the suspension or termination.

b. No person may submit claims for payment for any services or supplies provided by a person or affiliate who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

c. When the provisions of this subrule are violated, the department may sanction any person responsible for the violation.

79.2(6) *Notice to third parties.* When a sanction is imposed, the department may notify third parties of the findings made and the sanction imposed, including but not limited to law enforcement or peace officers and federal or state agencies. The imposition of a sanction is not required before the department may notify third parties of a person's conduct. In accordance with 42 CFR § 1002.212, the department must notify other state agencies, applicable licensing boards, the public, and Medicaid members, as provided in 42 CFR §§ 1001.2005 and 1001.2006, whenever the department initiates an exclusion under 42 CFR § 1002.210.

79.2(7) *Notice of violation.*

a. Any order of sanction shall be in writing and include the name of the person subject to sanction, identify the ground for the sanction and its effective date, and be sent to the person's last-known address. If the department sanctions a provider, the order of sanction shall also include the national provider identification number of the provider and be sent to the provider's last address on file within the medical assistance program. Proof of mailing to such address shall be conclusive evidence of proper service of the sanction upon the provider. The department of inspections and appeals is not required to comply with the additional notification provisions of 441—paragraph 7.10(7)*"c"* for appeals certified for hearing under this chapter.

b. In the case of a currently enrolled provider otherwise in good standing with all program requirements, the provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken. If the provider fails to do so, the sanction shall remain effective pending any subsequent appeal under 441—Chapter 7. If the provider attempts to show cause but the department determines the sanction should remain effective pending any subsequent appeal under 441—Chapter 7, the provider may seek a temporary stay of the department's action from the director or the director's designee by filing an application for stay with the appeals section. The director or the director's designee shall consider the factors listed in Iowa Code section 17A.19(5)*"c."*

79.2(8) *Suspension or withholding of payments.* The department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question due to a sanction, incorrect payment, civil monetary penalty, or other adverse action and may also suspend payment or participation pending a final determination. If the department withholds or suspends payments, it shall notify the person in writing within the time frames prescribed by federal law for cases related to a credible allegation of fraud, and within ten days for all other cases.

79.2(9) *Civil monetary penalties and interest.* Civil monetary penalties and interest assessed in accordance with 2013 Iowa Acts, Senate File 357, section 5 or section 11, are not allowable costs for any aspect of determining payment to a person within the medical assistance program. Under no circumstance shall the department reimburse a person for such civil monetary penalties or interest.

79.2(10) *Report and return of identified overpayment.*

a. If a person has identified an overpayment, the person must report and return the overpayment in the form and manner set forth in this subrule.

b. A person has identified an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the existence of the overpayment.

c. An overpayment required to be reported under 2013 Iowa Acts, Senate File 357, section 3, must be made in writing, addressed to the Program Integrity Unit of the Iowa Medicaid Enterprise, and contain all of the following:

(1) Person's name.

(2) Person's tax identification number.

(3) How the error was discovered.

(4) The reason for the overpayment.

(5) Claim number(s), as appropriate.

(6) Date(s) of service.

(7) Member identification number(s).

(8) National provider identification (NPI) number.

(9) Description of the corrective action plan to ensure the error does not occur again, if applicable.

(10) Whether the person has a corporate integrity agreement with the Office of the Inspector General (OIG) or is under the OIG Self-Disclosure Protocol or is presently under sanction by the department.

(11) The time frame and the total amount of refund for the period during which the problem existed that caused the refund.

(12) If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment.

(13) A refund in the amount of the overpayment.

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

[**ARC 1155C**, IAB 10/30/13, effective 1/1/14; **ARC 1695C**, IAB 10/29/14, effective 1/1/15]

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

79.3(1) *Financial (fiscal) records.*

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

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

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

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

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

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

(1) The provision of each service and each activity billed to the program; and

(2) First and last name of the member receiving the service.

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

(1) Medically necessary;

(2) Consistent with the diagnosis of the member's condition; and

(3) Consistent with professionally recognized standards of care.

c. Components.

(1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the

medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

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

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.
11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.
13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

(3) Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided and shall include the following:

1. The specific procedures or treatments performed.
2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. For those non-time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.
4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5)*"c"* or *"d,"* 441—paragraph 77.33(6)*"d,"* 441—paragraph 77.34(5)*"d,"* 441—paragraph 77.37(15)*"d,"* 441—paragraph 77.39(13)*"e,"* 441—paragraph 77.39(14)*"d,"* or 441—paragraph 77.46(5)*"i,"* or 441—subparagraph 78.9(10)*"a"*(1).
5. The name, dosage, and route of administration of any medication dispensed or administered as part of the service.
6. Any supplies dispensed as part of the service.
7. The first and last name and professional credentials, if any, of the person providing the service.
8. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.
9. For 24-hour care, documentation for every shift of the services provided, the member's response to the services provided, and the person who provided the services.

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

d. Basis for service requirements for specific services. The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to

document the reason for performing the service or activity, its medical necessity, or the level of care associated with it). These items will be specified on Form 470-4479, Documentation Checklist, when the Iowa Medicaid enterprise program integrity unit requests providers to submit records for review. (See paragraph 79.4(2)*"b."*)

(1) Physician (MD and DO) services:
1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.

(2) Pharmacy services:
1. Prescriptions.
2. Nursing facility physician order.
3. Telephone order.
4. Pharmacy notes.
5. Prior authorization documentation.

(3) Dentist services:
1. Treatment notes.
2. Anesthesia notes and records.
3. Prescriptions.

(4) Podiatrist services:
1. Service or office notes or narratives.
2. Certifying physician statement.
3. Prescription or order form.

(5) Certified registered nurse anesthetist services:
1. Service notes or narratives.
2. Preanesthesia physical examination report.
3. Operative report.
4. Anesthesia record.
5. Prescriptions.

(6) Other advanced registered nurse practitioner services:
1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.

(7) Optometrist and optician services:
1. Notes or narratives supporting eye examinations, medical services, and auxiliary procedures.
2. Original prescription or updated prescriptions for corrective lenses or contact lenses.
3. Prior authorization documentation.

(8) Psychologist services:
1. Service or office psychotherapy notes or narratives.
2. Psychological examination report and notes.

(9) Clinic services:
1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Nurses' notes.
4. Prescriptions.
5. Medication administration records.

(10) Services provided by rural health clinics or federally qualified health centers:
1. Service or office notes or narratives.
2. Form 470-2942, Prenatal Risk Assessment.
3. Procedure, laboratory, or test orders and results.
4. Immunization records.

(11) Services provided by community mental health centers:
1. Service referral documentation.
2. Initial evaluation.
3. Individual treatment plan.

4. Service or office notes or narratives.

5. Narratives related to the peer review process and peer review activities related to a member's treatment.

6. Written plan for accessing emergency services.

(12) Screening center services:

1. Service or office notes or narratives.

2. Immunization records.

3. Laboratory reports.

4. Results of health, vision, or hearing screenings.

(13) Family planning services:

1. Service or office notes or narratives.

2. Procedure, laboratory, or test orders and results.

3. Nurses' notes.

4. Immunization records.

5. Consent forms.

6. Prescriptions.

7. Medication administration records.

(14) Maternal health center services:

1. Service or office notes or narratives.

2. Procedure, laboratory, or test orders and results.

3. Form 470-2942, Prenatal Risk Assessment.

(15) Birthing center services:

1. Service or office notes or narratives.

2. Form 470-2942, Prenatal Risk Assessment.

(16) Ambulatory surgical center services:

1. Service notes or narratives (history and physical, consultation, operative report, discharge summary).

2. Physician orders.

3. Consent forms.

4. Anesthesia records.

5. Pathology reports.

6. Laboratory and X-ray reports.

(17) Hospital services:

1. Physician orders.

2. Service notes or narratives (history and physical, consultation, operative report, discharge summary).

3. Progress or status notes.

4. Diagnostic procedures, including laboratory and X-ray reports.

5. Pathology reports.

6. Anesthesia records.

7. Medication administration records.

(18) State mental hospital services:

1. Service referral documentation.

2. Resident assessment and initial evaluation.

3. Individual comprehensive treatment plan.

4. Service notes or narratives (history and physical, therapy records, discharge summary).

5. Form 470-0042, Case Activity Report.

6. Medication administration records.

(19) Services provided by skilled nursing facilities, nursing facilities, and nursing facilities for persons with mental illness:

1. Physician orders.

2. Progress or status notes.

3. Service notes or narratives.
4. Procedure, laboratory, or test orders and results.
5. Nurses' notes.
6. Physical therapy, occupational therapy, and speech therapy notes.
7. Medication administration records.
8. Form 470-0042, Case Activity Report.

(20) Services provided by intermediate care facilities for persons with mental retardation:

1. Physician orders.
2. Progress or status notes.
3. Preliminary evaluation.
4. Comprehensive functional assessment.
5. Individual program plan.
6. Form 470-0374, Resident Care Agreement.
7. Program documentation.
8. Medication administration records.
9. Nurses' notes.
10. Form 470-0042, Case Activity Report.

(21) Services provided by psychiatric medical institutions for children:

1. Physician orders or court orders.
2. Independent assessment.
3. Individual treatment plan.
4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Form 470-0042, Case Activity Report.
6. Medication administration records.

(22) Hospice services:

1. Physician certifications for hospice care.
2. Form 470-2618, Election of Medicaid Hospice Benefit.
3. Form 470-2619, Revocation of Medicaid Hospice Benefit.
4. Plan of care.
5. Physician orders.
6. Progress or status notes.
7. Service notes or narratives.
8. Medication administration records.
9. Prescriptions.

(23) Services provided by rehabilitation agencies:

1. Physician orders.
2. Initial certification, recertifications, and treatment plans.
3. Narratives from treatment sessions.
4. Treatment and daily progress or status notes and forms.

(24) Home- and community-based habilitation services:

1. Notice of decision for service authorization.
2. Service plan (initial and subsequent).
3. Service notes or narratives.

(25) Behavioral health intervention:

1. Order for services.
2. Comprehensive treatment or service plan (initial and subsequent).
3. Service notes or narratives.

(26) Services provided by area education agencies and local education agencies:

1. Service notes or narratives.
2. Individualized education program (IEP).
3. Individual health plan (IHP).
4. Behavioral intervention plan.

(27) Home health agency services:

1. Plan of care or plan of treatment.
2. Certifications and recertifications.
3. Service notes or narratives.
4. Physician orders or medical orders.

(28) Services provided by independent laboratories:

1. Laboratory reports.
2. Physician order for each laboratory test.

(29) Ambulance services:

1. Documentation on the claim or run report supporting medical necessity of the transport.
2. Documentation supporting mileage billed.

(30) Services of lead investigation agencies:

1. Service notes or narratives.
2. Child's lead level logs (including laboratory results).
3. Written investigation reports to family, owner of building, child's medical provider, and local childhood lead poisoning prevention program.
4. Health education notes, including follow-up notes.

(31) Medical supplies:

1. Prescriptions.
2. Certificate of medical necessity.
3. Prior authorization documentation.
4. Medical equipment invoice or receipt.

(32) Orthopedic shoe dealer services:

1. Service notes or narratives.
2. Prescriptions.
3. Certifying physician's statement.

(33) Case management services, including HCBS case management services:

1. Form 470-3956, MR/CMI/DD Case Management Service Authorization Request, for services authorized before May 1, 2007.
2. Notice of decision for service authorization.
3. Service notes or narratives.
4. Social history.
5. Comprehensive service plan.
6. Reassessment of member needs.
7. Incident reports in accordance with 441—subrule 24.4(5).

(34) Early access service coordinator services:

1. Individualized family service plan (IFSP).
2. Service notes or narratives.

(35) Home- and community-based waiver services, other than case management:

1. Notice of decision for service authorization.
2. Service plan.
3. Service logs, notes, or narratives.
4. Mileage and transportation logs.
5. Log of meal delivery.
6. Invoices or receipts.
7. Forms 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record.

(36) Physical therapist services:

1. Physician order for physical therapy.
2. Initial physical therapy certification, recertifications, and treatment plans.
3. Treatment notes and forms.
4. Progress or status notes.

(37) Chiropractor services:

1. Service or office notes or narratives.
2. X-ray results.

(38) Hearing aid dealer and audiologist services:

1. Physician examinations and audiological testing (Form 470-0361, Sections A, B, and C).
2. Documentation of hearing aid evaluation and selection (Form 470-0828).
3. Waiver of informed consent.
4. Prior authorization documentation.
5. Service or office notes or narratives.

(39) Behavioral health services:

1. Assessment.
2. Individual treatment plan.
3. Service or office notes or narratives.

(40) Health home services:

1. Comprehensive care management plan.
2. Care coordination and health promotion plan.
3. Comprehensive transitional care plan, including appropriate follow-up, from inpatient to other settings.
4. Documentation of member and family support (including authorized representatives).
5. Documentation of referral to community and social support services, if relevant.

(41) Services of public health agencies:

1. Service or office notes or narratives.
2. Immunization records.
3. Results of communicable disease testing.

(42) Community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services:

1. Department-approved standardized neurobehavioral assessment tool.
2. Community-based neurobehavioral treatment order.
3. Treatment plan.
4. Clinical records documenting diagnosis and treatment history.
5. Progress or status notes.
6. Service notes or narratives.
7. Procedure, laboratory, or test orders and results.
8. Therapy notes including but not limited to occupational therapy, physical therapy, and speech-language pathology services as applicable.
9. Medication administration records.

(43) Child care medical services:

1. Plan of care.
2. Certification and recertification.
3. Service notes or narratives.
4. Physician orders or medical orders.
5. Abbreviation list (a copy of the abbreviation list utilized within the member's record).
6. If initials or incomplete signatures are noted within the member's record, a signature log (a typed listing of each provider's name, including initials, professional credentials and title, followed by the individual provider's signature).

e. Corrections. A provider may correct the medical record before submitting a claim for reimbursement.

(1) Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

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

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

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

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

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

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

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

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

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

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 8262B**, IAB 11/4/09, effective 12/9/09; **ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 0198C**, IAB 7/11/12, effective 7/1/12; **ARC 0358C**, IAB 10/3/12, effective 11/7/12; **ARC 0711C**, IAB 5/1/13, effective 7/1/13; **ARC 1695C**, IAB 10/29/14, effective 1/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 2341C**, IAB 1/6/16, effective 2/10/16]

441—79.4(249A) Reviews and audits.

79.4(1) *Definitions.*

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

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

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

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

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

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

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

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

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

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

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

"Universe" means all items or claims under review or audit during the period specified by the audit or review.

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

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

(1) The department has correctly paid claims for goods or services.

(2) The provider has furnished the services to Medicaid members.

(3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.

(4) The goods or services provided were in accordance with Iowa Medicaid policy.

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

c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

79.4(3) *Audit or review procedures.* The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.

a. Upon a written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided in paragraph *"b."*

b. Extension of time limit for submission.

(1) The department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider's designee. The request must:

1. Establish good cause for the delay in submitting the records; and

2. Be received by the department before the date the records are due to be submitted.

(2) For purposes of these rules, "good cause" has the same meaning as in Iowa Rule of Civil Procedure 1.977.

(3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.

(4) The provider may appeal the department's denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.

c. The department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.

(1) For an announced on-site review or audit, the department's employee or authorized agent may give as little as one day's advance notice of the review or audit and the records and supporting documentation to be reviewed.

(2) Notice is not required for unannounced on-site reviews and audits.

(3) In an on-site review or audit, the conclusion of that review or audit shall be considered the end of the period within which to produce records.

d. Audit or review procedures may include, but are not limited to, the following:

(1) Comparing clinical and fiscal records with each claim.

(2) Interviewing members who received goods or services and employees of providers.

(3) Examining third-party payment records.

(4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.

(5) Examining all documents related to the services for which Medicaid was billed.

e. Use of statistical sampling techniques. The department's procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.

(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.

(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures shall constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

f. Self-audit. The department may require a provider to conduct a self-audit and report the results of the self-audit to the department.

79.4(4) *Preliminary report of audit or review findings.* If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

79.4(5) *Disagreement with audit or review findings.* If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.

a. Reevaluation request. A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.

(1) If the audit or review is being performed by the Iowa Medicaid enterprise surveillance and utilization review services unit, the request should be addressed to: IME SURS Unit, P.O. Box 36390, Des Moines, Iowa 50315.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to: Iowa Department of Human Services, Attention: Fiscal Management Division, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. Additional information. A provider that has made a reevaluation request pursuant to paragraph *"a"* of this subrule may submit clarifying information or supplemental documentation that was not previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph *"c"* of this subrule.

c. Disagreement with sampling results. When the department's audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department's sample. Any such audit or review must:

(1) Be arranged and paid for by the provider.

(2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.

(3) Be conducted by a certified public accountant if the issues relate to fiscal records.

(4) Demonstrate that bills and records that were not audited or reviewed in the department's sample are in compliance with program regulations.

(5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

79.4(6) *Finding and order for repayment.* Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department shall issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

79.4(7) *Appeal by provider of care.* A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment. Records not provided to the department during the review process set forth in subrule 79.4(3) or 79.4(5) shall not be admissible

in any subsequent contested case proceeding arising out of a finding and order for repayment of any overpayment identified under subrule 79.4(6). This provision does not preclude providers that have provided records to the department during the review process set forth in subrule 79.4(3) or 79.4(5) from presenting clarifying information or supplemental documentation in the appeals process in order to defend against any overpayment identified under subrule 79.4(6). This provision is intended to minimize potential duplication of effort and delay in the audit or review process, minimize unnecessary appeals, and otherwise forestall fraud, waste, and abuse in the Iowa Medicaid program.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 0712C**, IAB 5/1/13, effective 7/1/13; **ARC 1155C**, IAB 10/30/13, effective 1/1/14]

441—79.5(249A) Nondiscrimination on the basis of handicap. All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and Federal regulations 45 CFR Part 84, as amended to December 19, 1990, which prohibit discrimination on the basis of handicap in all Department of Health and Human Services funded programs.

This rule is intended to implement Iowa Code subsection 249A.4(6).

441—79.6(249A) Provider participation agreement. Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on Form 470-2965, Agreement Between Provider of Medical and Health Services and the Iowa Department of Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 441—79.3(249A).

79.6(2) That the charges as determined in accordance with the department's policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

79.6(3) That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

This rule is intended to implement Iowa Code section 249A.4.

441—79.7(249A) Medical assistance advisory council.

79.7(1) *Officers.* Officers shall be a chairperson and a vice-chairperson.

a. The director of public health shall serve as chairperson of the council. Elections for vice-chairperson will be held the first meeting after the beginning of the calendar year.

b. The vice-chairperson's term of office shall be two years. A vice-chairperson shall serve no more than two terms.

c. The vice-chairperson shall serve in the absence of the chairperson.

d. The chairperson and vice-chairperson shall have the right to vote on any issue before the council.

e. The chairperson shall appoint a committee of not less than three members to nominate vice-chairpersons and shall appoint other committees approved by the council.

79.7(2) *Membership.* The membership of the council and its executive committee shall be as prescribed at Iowa Code section 249A.4B, subsections 2and 3.

79.7(3) *Expenses, staff support, and technical assistance.* Expenses of the council and executive committee, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations. The department shall provide staff support and independent technical assistance to the council and the executive committee.

79.7(4) *Meetings.* The council shall meet no more than quarterly. The executive committee shall meet on a monthly basis. Meetings may be called by the chairperson, upon written request of at least 50 percent of the members, or by the director of the department of human services.

a. Meetings shall be held in the Des Moines, Iowa, area, unless other notification is given.

b. Written notice of council meetings shall be mailed at least two weeks in advance of the meeting. Each notice shall include an agenda for the meeting.

79.7(5) *Procedures.*

a. A quorum shall consist of 50 percent of the voting members.

b. Where a quorum is present, a position is carried by two-thirds of the council members present.

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member and to the executive office of each professional group or business entity represented.

d. Notice shall be given to a professional group or business entity represented on the council when the representative of that group or entity has been absent from three consecutive meetings.

e. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(6) *Duties.*

a. Executive committee. Based upon the deliberations of the medical assistance advisory council and the executive committee, the executive committee shall make recommendations to the director regarding the budget, policy, and administration of the medical assistance program. Such recommendations may include:

(1) Recommendations on the reimbursement for medical services rendered by providers of services.

(2) Identification of unmet medical needs and maintenance needs which affect health.

(3) Recommendations for objectives of the program and for methods of program analysis and evaluation, including utilization review.

(4) Recommendations for ways in which needed medical supplies and services can be made available most effectively and economically to the program recipients.

(5) Advice on such administrative and fiscal matters as the director of the department of human services may request.

b. Council. The medical assistance advisory council shall:

(1) Advise the professional groups and business entities represented and act as liaison between them and the department.

(2) Report at least annually to the professional groups and business entities represented.

(3) Perform other functions as may be provided by state or federal law or regulation.

(4) Communicate information considered by the council to the professional groups and business entities represented.

79.7(7) *Responsibilities.*

a. Recommendations of the council shall be advisory and not binding upon the department of human services or the professional groups and business entities represented. The director of the department of human services shall consider the recommendations offered by the council and the executive committee in:

(1) The director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3, and

(2) Implementation of medical assistance program policies.

b. The council may choose subjects for consideration and recommendation. It shall consider all matters referred to it by the department of human services.

c. Any matter referred by a member organization or body shall be considered upon an affirmative vote of the council.

d. The department shall provide the council with reports, data, and proposed and final amendments to rules, laws, and guidelines, for its information, review, and comment.

e. The department shall present the annual budget for the medical assistance program for review and comment.

f. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

g. The department shall maintain a current list of members on the council and executive committee.

[**ARC 8263B**, IAB 11/4/09, effective 12/9/09]

441—79.8(249A) Requests for prior authorization. This rule governs requests for prior authorization for services not provided through a managed care organization. For services provided through a managed care organization, the prior authorization request is submitted, reviewed, and authorized by the managed care organization.

79.8(1) *Making the request.*

a. Providers may submit requests for prior authorization for any items or procedures by mail or by facsimile transmission (fax) using Form 470-0829, Request for Prior Authorization, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs must be submitted on any Request for Prior Authorization form designated for the drug being requested in the preferred drug list published pursuant to Iowa Code chapter 249A.

b. Providers shall send requests for prior authorization to the Iowa Medicaid enterprise. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought, according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-3970, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-3970 the attachment control number submitted on the ASC X12N 278 electronic transaction.

79.8(2) The policy applies to services or items specifically designated as requiring prior authorization.

79.8(3) The provider shall receive a notice of approval or denial for all requests.

a. In the case of prescription drugs, notices of approval or denial will be faxed to the prescriber and pharmacy.

b. Decisions regarding approval or denial will be made within 24 hours from the receipt of the prior authorization request. In cases where the request is received during nonworking hours, the time limit will be construed to start with the first hour of the normal working day following the receipt of the request.

79.8(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.8(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.8(6) If a provider is unsure if an item or service is covered because it is rare or unusual, the provider may submit a request for prior approval in the same manner as other requests for prior approval in 79.8(1).

79.8(7) Requests for prior approval of services shall be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78.

a. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

(1) The conditions for payment outlined in the provider manual with reference to coverage and duration.

(2) The determination made by the Medicare program unless specifically stated differently in state law or rule.

(3) The recommendation to the department from the appropriate advisory committee.

(4) Whether there are other less expensive procedures which are covered and which would be as effective.

(5) The advice of an appropriate professional consultant.

b. When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

79.8(8) The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of the policies is available in the provider manual distributed and updated to all participating providers.

79.8(9) The Iowa Medicaid enterprise shall issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 7. The Iowa Medicaid enterprise shall mail the notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

79.8(10) If a request for prior approval is denied by the Iowa Medicaid enterprise, the request may be resubmitted for reconsideration with additional information justifying the request. The aggrieved party may file an appeal in accordance with 441—Chapter 7.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.9(1) Medicare definitions and policies shall apply to services provided unless specifically defined differently.

79.9(2) The services covered by Medicaid shall:

a. Be consistent with the diagnosis and treatment of the patient's condition.

b. Be in accordance with standards of good medical practice.

c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.

d. Be the least costly type of service which would reasonably meet the medical need of the patient.

e. Be eligible for federal financial participation unless specifically covered by state law or rule.

f. Be within the scope of the licensure of the provider.

g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.

h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

79.9(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.9(4) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

79.9(5) Coverage in public institutions. Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid.

79.9(6) The acceptance of Medicaid funds by means of a prospective or interim rate creates an express trust. The Medicaid funds received constitute the trust res. The trust terminates when the rate is retrospectively adjusted or otherwise finalized and, if applicable, any Medicaid funds determined to be owed are repaid in full to the department.

79.9(7) Incorrect payment.

a. Except as provided in paragraph 79.9(7)*"b,"* medical assistance funds are incorrectly paid whenever an individual who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.

b. Notwithstanding paragraph 79.9(7)*"a,"* medical assistance funds are not incorrectly paid when an individual who serves as a member's legal representative provides services to the member under a home- and community-based services waiver consumer-directed attendant care agreement or under a

consumer choices option employment agreement in effect on or after December 31, 2013. For purposes of this paragraph, "legal representative" means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger.

79.9(8) The rules of the medical assistance program shall not be construed to require payment of medical assistance funds, in whole or in part, directly or indirectly, overtly or covertly, for the provision of non-Medicaid services. The rules of the medical assistance program shall be interpreted in such a manner to minimize any risk that medical assistance funds might be used to subsidize services to persons other than members of the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and 2014 Iowa Acts, Senate File 2320.
[**ARC 1155C**, IAB 10/30/13, effective 1/1/14; **ARC 1610C**, IAB 9/3/14, effective 8/13/14]

441—79.10(249A) Requests for preadmission review. The inpatient hospitalization of Medicaid recipients is subject to preadmission review by the Iowa Medicaid enterprise (IME) medical services unit as required in rule 441—78.3(249A).

79.10(1) The patient's admitting physician, the physician's designee, or the hospital will contact the IME medical services unit to request approval of Medicaid coverage for the hospitalization, according to instructions issued to providers by the IME medical services unit and instructions in the Medicaid provider manual.

79.10(2) Medicaid payment will not be made to the hospital if the IME medical services unit denies the procedure requested in the preadmission review.

79.10(3) The IME medical services unit shall issue a letter of denial to the patient, the physician, and the hospital when a request is denied. The patient, the physician, or the hospital may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.10(4) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit according to 441—Chapter 7.

79.10(5) The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter 73.

This rule is intended to implement Iowa Code section 249A.4.
[**ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—79.11(249A) Requests for preprocedure surgical review. The Iowa Medicaid enterprise (IME) medical services unit conducts a preprocedure review of certain frequently performed surgical procedures to determine the necessity of the procedures and if Medicaid payment will be approved according to requirements found in 441—subrules 78.1(19), 78.3(18), and 78.26(3).

79.11(1) The physician must request approval from the IME medical services unit when the physician expects to perform a surgical procedure appearing on the department's preprocedure surgical review list published in the Medicaid provider manual. All requests for preprocedure surgical review shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid provider manual and instructions issued to providers by the IME medical services unit.

79.11(2) The IME medical services unit shall issue the physician a validation number for each request and shall advise whether payment for the procedure will be approved or denied.

79.11(3) Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, i.e., hospital or ambulatory surgical center, if the IME medical services unit does not give approval.

79.11(4) The IME medical services unit shall issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.11(5) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit in accordance with 441—Chapter 7.

79.11(6) The requirement to obtain preprocedure surgical review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the procedure has been obtained from the patient manager as described in 441—Chapter 73.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—79.12(249A) Advance directives. "Advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving medical care through the provider or organization to comply with state law regarding advance directives as follows:

79.12(1) A hospital at the time of a person's admission as an inpatient, a home health care provider in advance of a person's coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and a health maintenance organization at the time of enrollment of the person with the organization shall provide written information to each adult which explains the person's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and the provider's policies regarding the implementation of these rights.

79.12(2) The provider or organization shall document in the person's medical record whether or not the person has executed an advance directive.

79.12(3) The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.

79.12(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.12(5) The provider or organization shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this rule shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any provider or organization which as a matter of conscience cannot implement an advance directive.

This rule is intended to implement Iowa Code section 249A.4.

441—79.13(249A) Requirements for enrolled Medicaid providers supplying laboratory services. Medicaid enrolled entities providing laboratory services are subject to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, and implementing federal regulations published at 42 CFR Part 493 as amended to December 29, 2000. Medicaid payment shall not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

This rule is intended to implement Iowa Code section 249A.4.

441—79.14(249A) Provider enrollment.

79.14(1) Application request. Iowa Medicaid providers, including those enrolled with a managed care organization, shall begin the enrollment process by completing the appropriate application on the Iowa Medicaid enterprise Web site. Managed care organizations and fiscal agents are exempt from completing an application.

a. Providers of home- and community-based waiver services shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date.

b. Providers enrolling as ordering or referring providers shall submit Form 470-5111, Iowa Medicaid Ordering/Referring Provider Enrollment Application.

c. All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.

d. A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

e. An intermediate care facility for persons with an intellectual disability shall also complete the process set forth in 441—subrule 82.3(1).

79.14(2) Submittal of application. The provider shall submit the appropriate application forms, including the application fee, if required, to the Iowa Medicaid enterprise provider services unit by personal delivery, by e-mail, via online enrollment systems, or by mail to P.O. Box 36450, Des Moines, Iowa 50315.

a. The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

b. With the application form, an assertive community treatment program shall submit Form 470-4842, Assertive Community Services (ACT) Provider Agreement Addendum, and agree to file with the department an annual report containing information to be used for rate setting, including:

(1) Data by practitioner on the utilization by Medicaid members of all the services included in assertive community treatment, and

(2) Cost information by practitioner type and by type of service actually delivered as part of assertive community treatment.

c. With the application form, or as a supplement to a previously submitted application, providers of health home services shall submit Form 470-5100, Health Home Provider Agreement.

d. Application fees.

(1) Providers who are enrolling or reenrolling in the Iowa Medicaid program shall submit an application fee with their application unless they are exempt as set forth in this paragraph.

(2) Fee amount. The application fee shall be in the amount prescribed by the Secretary of the U.S. Department of Health and Human Services (the Secretary) for the calendar year in which the application is submitted and in accordance with 42 U.S.C. 1395cc(j)(2)(C).

(3) Nonrefundable. The application fee is nonrefundable, except if submitted with one of the following:

1. A hardship exception request that is subsequently approved by the Secretary.

2. An application that is subsequently denied as a result of a temporary moratorium under 2013 Iowa Acts, Senate File 357, section 12.

3. An application or other transaction in which the application fee is not required.

(4) The process for enrolling or reenrolling a provider will not begin until the application fee has been received by the department or a hardship exception request has been approved by the Secretary.

(5) Exempt providers. The following providers shall not be required to submit an application fee:

1. Individual physicians or nonphysician practitioners.

2. Providers that are enrolled in Medicare, another state's Medicaid program or another state's children's health insurance program.

3. Providers that have paid the applicable application fee within 12 months of the date of application submission to a Medicare contractor or another state.

(6) All application fees collected shall be used for the costs associated with the screening procedures as described in subrule 79.14(4). Any unused portion of the application fees collected shall be returned to the federal government in accordance with 42 CFR § 455.460.

79.14(3) Program integrity information requirements.

a. All providers, including but not limited to managed care organizations and Medicaid fiscal agents, applying for participation in the Iowa Medicaid program must disclose all information required to be submitted pursuant to 42 CFR Part 455. In addition, all providers shall disclose any current, or previous, direct or indirect affiliation with a present or former Iowa Medicaid provider that:

(1) Has any uncollected debt owed to Medicaid or any other health care program funded by any governmental entity, including but not limited to the federal and state of Iowa governments;

(2) Has been or is subject to a payment suspension under a federally funded health care program;

(3) Has been excluded from participation under Medicaid, Medicare, or any other federally funded health care program;

(4) Has had its billing privileges denied or revoked;

(5) Has been administratively dissolved by the Iowa secretary of state, or similar action has been taken by a comparable agency in another state; or

(6) Shares a national provider identification (NPI) number or tax ID number with another provider that meets the criteria specified in subparagraph 79.14(3)*"a"*(1), (2), (3), (4), or (5).

b. The Iowa Medicaid enterprise may deny enrollment to a provider applicant or disenroll a current provider that has any affiliation as set forth in this rule if the department determines that the affiliation poses a risk of fraud, waste, or abuse. Such denial or disenrollment is appealable under 441—Chapter 7 but, notwithstanding any provision to the contrary in that chapter, the provider shall bear the burden to prove by clear and convincing evidence that the affiliation does not pose any risk of fraud, waste, or abuse. The Iowa Medicaid enterprise shall deny enrollment to or shall immediately disenroll any person that the Iowa Medicaid enterprise, Medicare, or any other state Medicaid program has ever terminated under rule 441—79.2(249A) or a similar provision and shall deny enrollment to any person presently suspended from participation, or who would be subject to a suspension, under paragraph 79.2(3)*"c."* Further, a person sanctioned under rule 441—79.2(249A) or a similar provision may not manage consumer choices option (CCO) funds for a member.

c. For purposes of this rule, the term "direct or indirect affiliation" includes but is not limited to relationships between individuals, business entities, or a combination of the two. The term includes but is not limited to direct or indirect business relationships that involve:

(1) A compensation arrangement;

(2) An ownership arrangement;

(3) Managerial authority over any member of the affiliation;

(4) The ability of one member of the affiliation to control or influence any other; or

(5) The ability of a third party to control or influence any member of the affiliation.

d. Notwithstanding any previous successful enrollment in the medical assistance program, the passing of any background check by the department or any other entity, or similar prior approval for participation as a provider in the medical assistance program, in whole or in part, disenrollment from the medical assistance program is mandatory when, in the case of a corporation or similar entity, 5 percent or more of the corporation or similar entity is owned, controlled, or directed by a person who (1) has within the last five years been listed on any dependent adult abuse registry, child abuse registry, or sex offender registry; (2) has pled guilty or nolo contendere to, or was convicted of, any crime punishable by a term of imprisonment greater than five years; (3) has, within the last five years, pled guilty or nolo contendere to, or was convicted of, any controlled substance offense; (4) has, within the last ten years, pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty punishable by a term of imprisonment greater than one year but not more than five years; or (5) within the last ten years, has on more than one occasion pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty.

79.14(4) Screening procedures and requirements. Providers applying for participation in the Iowa Medicaid program shall be subject to the "limited," "moderate," or "high" categorical risk screening procedures and requirements in accordance with 42 CFR §455.450.

a. For the types of providers that are recognized as a provider under the Medicare program, the Iowa Medicaid enterprise shall use the same categorical risk screening procedures and requirements assigned to that provider type by Medicare pursuant to 42 CFR §424.518.

b. Provider types not assigned a screening level by the Medicare program shall be subject to the procedures of the "limited" risk screening level pursuant to 42 CFR §455.450.

c. Adjustment of risk level. The Iowa Medicaid enterprise shall adjust the categorical risk screening procedures and requirements from "limited" or "moderate" to "high" when any of the following occurs:

(1) The Iowa Medicaid enterprise imposes a payment suspension on a provider based on a credible allegation of fraud, waste, or abuse; the provider has an existing Medicaid overpayment; or within the previous ten years, the provider has been excluded by the Office of the Inspector General or another state's Medicaid program; or

(2) The Iowa Medicaid enterprise or the Centers for Medicare and Medicaid Services in the previous six months lifted a temporary moratorium for the particular provider type, and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

79.14(5) Notification. A provider shall be notified of the decision on the provider's application within 30 calendar days of receipt by the Iowa Medicaid enterprise provider services unit of a complete and correct application with all required documents, including, but not limited to, if applicable, any application fees or screening results.

79.14(6) A provider that is not approved as the Medicaid provider type requested shall have the right to appeal under 441—Chapter 7.

79.14(7) Effective date of approval. An application shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application with all required documents by the Iowa Medicaid enterprise provider services unit.

79.14(8) A provider approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.14(9) No payment shall be made to a provider for care or services provided prior to the effective date of the Iowa Medicaid enterprise's approval of an application.

79.14(10) Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(11) An amendment to an application shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(12) A provider that has not submitted a claim in the last 24 months will be sent a notice asking if the provider wishes to continue participation. A provider that fails to reply to the notice within 30 calendar days of the date on the notice will be terminated as a provider. Providers that do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(13) Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 35 days of the change. Pertinent changes include, but are not limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, telephone number, or any information required to be disclosed by subrule 79.14(3).

a. When a provider reports false, incomplete, or misleading information on any application or reapplication, or fails to provide current information within the 35-day period, the Iowa Medicaid enterprise may immediately terminate the provider's Medicaid enrollment. The termination may be appealed under 441—Chapter 7. Such termination remains in effect notwithstanding any pending appeal.

b. When the department incurs an informational tax-reporting fine or is required to repay the federal share of medical assistance paid to the provider because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine or repayment shall be the responsibility of the individual provider to the extent that the fine or repayment relates to or arises out of the provider's failure to keep all provider information current.

(1) The provider shall remit the amount of the fine or repayment to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine or repayment may be appealed under 441—Chapter 7.

79.14(14) Provider termination or denial of enrollment. The Iowa Medicaid enterprise must terminate or deny any provider enrollment when the provider has violated any requirements identified in 42 CFR §455.416.

79.14(15) Temporary moratoria. The Iowa Medicaid enterprise must impose any temporary moratorium pursuant to 2013 Iowa Acts, Senate File 357, section 12.

79.14(16) Provider revalidation. Providers are required to complete the application process and screening requirements as detailed in this rule every five years.

79.14(17) Recoupment. A provider is strictly liable for any failure to disclose the information required by subrule 79.14(3) or any failure to report a change required by subrule 79.14(13). The department shall recoup as incorrectly paid all funds paid to the provider before a complete disclosure or report of change was made. The department shall also recoup as incorrectly paid all funds to any provider that billed the Iowa Medicaid enterprise while the provider was administratively dissolved by the Iowa secretary of state or comparable agency of another state, even if the provider subsequently obtains a retroactive reinstatement from the Iowa secretary of state or similar action was taken against the provider by a comparable agency of another state.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 0198C**, IAB 7/11/12, effective 7/1/12; **ARC 0580C**, IAB 2/6/13, effective 4/1/13; **ARC 1153C**, IAB 10/30/13, effective 1/1/14; **ARC 1695C**, IAB 10/29/14, effective 1/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—79.15(249A) Education about false claims recovery. The provisions in this rule apply to any entity that has received medical assistance payments totaling at least $5 million during a federal fiscal year (ending on September 30). For entities whose payments reach this threshold, compliance with this rule is a condition of receiving payments under the medical assistance program during the following calendar year.

79.15(1) *Policy requirements.* Any entity whose medical assistance payments meet the threshold shall:

a. Establish written policies for all employees of the entity and for all employees of any contractor or agent of the entity, including management, which provide detailed information about:

(1) The False Claims Act established under Title 31, United States Code, Sections 3729 through 3733;

(2) Administrative remedies for false claims and statements established under Title 31, United States Code, Chapter 38;

(3) Any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) Whistle blower protections under the laws described in subparagraphs (1) to (3) with respect to the role of these laws in preventing and detecting fraud, waste, and abuse in federal health care programs, as defined in Title 42, United States Code, Section 1320a-7b(f); and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

b. Include in any employee handbook a specific discussion of:

(1) The laws described in paragraph 79.15(1)*"a"*;

(2) The rights of employees to be protected as whistle blowers; and

(3) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

79.15(2) *Reporting requirements.*

a. Any entity whose medical assistance payments meet the specified threshold during a federal fiscal year shall provide the following information to the Iowa Medicaid enterprise by the following December 31:

(1) The name, address, and national provider identification numbers under which the entity receives payment;

(2) Copies of written or electronic policies that meet the requirements of subrule 79.15(1); and

(3) A written description of how the policies are made available and disseminated to all employees of the entity and to all employees of any contractor or agent of the entity.

b. The information may be provided by:

(1) Mailing the information to the IME Program Integrity Unit, P.O. Box 36390, Des Moines, Iowa 50315; or

(2) Faxing the information to (515)725-1354.

79.15(3) *Enforcement.* Any entity that fails to comply with the requirements of this rule shall be subject to sanction under rule 441—79.2(249A), including probation, suspension or withholding of payments, and suspension or termination from participation in the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and Public Law 109-171, Section 6032.

[**ARC 9440B**, IAB 4/6/11, effective 4/1/11]

441—79.16(249A) Electronic health record incentive program. The department has elected to participate in the electronic health record (EHR) incentive program authorized under Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law No. 111-5. The electronic health record incentive program provides incentive payments to eligible hospitals and professionals participating in the Iowa Medicaid program that adopt and successfully demonstrate meaningful use of certified electronic health record technology.

79.16(1) *State elections.* In addition to the statutory provisions in ARRA Section 4201, the electronic health record incentive program is governed by federal regulations at 42 CFR Part 495 as amended to September 4, 2012. In compliance with the requirements of federal law, the department establishes the following state options under the Iowa electronic health record incentive program:

a. For purposes of the term "hospital-based eligible professional (EP)" as set forth in 42 CFR Section 495.4 as amended to September 4, 2012, the department elects the calendar year preceding the payment year as the period used to gather data to determine whether or not an eligible professional is "hospital-based" for purposes of the regulation.

b. For purposes of calculating patient volume as required by 42 CFR Section 495.306 as amended to September 4, 2012, the department has elected that eligible providers may use either:

(1) The patient encounter methodology found in 42 CFR Section 495.306(c) as amended to September 4, 2012, or

(2) The patient panel methodology found in 42 CFR Section 495.306(d) as amended to September 4, 2012.

c. For purposes of 42 CFR Section 495.310(g)(1)(i)(B) as amended to September 4, 2012, the "12-month period selected by the state" shall mean the hospital fiscal year.

d. For purposes of 42 CFR Section 495.310(g)(2)(i) as amended to September 4, 2012, the "12-month period selected by the state" shall mean the hospital fiscal year.

79.16(2) *Eligible providers.* To be deemed an "eligible provider" for the electronic health record incentive program, a provider must satisfy the applicable criterion in each paragraph of this subrule:

a. The provider must be currently enrolled as an Iowa Medicaid provider.

b. The provider must be one of the following:

(1) An eligible professional, listed as:

1. A physician,
2. A dentist,
3. A certified nurse midwife,
4. A nurse practitioner, or
5. A physician assistant practicing in a federally qualified health center or a rural health clinic when the physician assistant is the primary provider, clinical or medical director, or owner of the site.

(2) An acute care hospital, as defined in 42 CFR Section 495.302 as amended to September 4, 2012.

(3) A children's hospital, as defined in 42 CFR Section 495.302 as amended to September 4, 2012.

c. For the year for which the provider is applying for an incentive payment:

(1) An acute care hospital must have 10 percent Medicaid patient volume.

(2) An eligible professional must have at least 30 percent of the professional's patient volume enrolled in Medicaid, except that:

1. A pediatrician must have at least 20 percent Medicaid patient volume. For purposes of this subrule, a "pediatrician" is a physician who is board-certified in pediatrics by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics or who is eligible for board certification.

2. When a professional has at least 50 percent of patient encounters in a federally qualified health center or rural health clinic, patients who were furnished services either at no cost or at a reduced cost based on a sliding scale or ability to pay, patients covered by the HAWK-I program, and Medicaid members may be counted to meet the 30 percent threshold.

79.16(3) *Application and agreement.* Any eligible provider that intends to participate in the Iowa electronic health record incentive program must declare the intent to participate by registering with the CMS Registration and Attestation Web site, as developed by the Centers for Medicare and Medicaid Services (CMS). CMS will notify the department of an eligible provider's application for the incentive payment.

a. Upon receipt of an application for participation in the program, the department will contact the applicant with instructions for accessing the Iowa EHR Medicaid incentive payment administration Web site at www.imeincentives.com. The applicant shall use the Web site to:

(1) Attest to the applicant's qualifications to receive the incentive payment, and

(2) Digitally sign Form 470-4976, Iowa Electronic Health Record Incentive Program Provider Agreement.

b. For the second year of participation, eligible providers must submit meaningful use and clinical quality measures to the department, either through attestation or electronically as required by the department.

c. The department shall verify the applicant's eligibility, including patient volume and practice type, and the applicant's use of certified electronic health record technology.

79.16(4) *Payment.* The department shall issue the incentive payment only after confirming that all eligibility and performance criteria have been satisfied. Payments will be processed and paid to the tax identification number designated by the applicant. The department will communicate the payment or denial of payment to the CMS Registration and Attestation Web site.

a. The primary communication channel from the department to the provider will be the Iowa EHR Medicaid incentive payment administration Web site. If the department finds that the applicant is ineligible or has failed to achieve the criteria necessary for the payment, the department shall notify the provider through the Web site. Providers shall access the Web site to determine the status of their payment, including whether the department denied payment and the reason for the denial.

b. Providers must retain records supporting their eligibility for the incentive payment for a minimum of six years. The department will select providers for audit after issuance of an incentive payment. Incentive recipients shall cooperate with the department by providing proof of:

(1) Eligibility,

(2) Purchase of certified electronic health record technology, and

(3) Meaningful use of electronic health record technology.

79.16(5) *Administrative appeal.* Any eligible provider or any provider that claims to be an eligible provider and who has been subject to an adverse action related to the Iowa electronic health record incentive program may seek review of the department's action pursuant to 441—Chapter 7. Appealable issues include:

a. Provider eligibility determination.

b. Incentive payments.

c. Demonstration of adopting, implementing, upgrading and meaningful use of technology.

This rule is intended to implement Iowa Code section 249A.4 and Public Law No. 111-5.

[**ARC 9254B**, IAB 12/1/10, effective 1/1/11; **ARC 9531B**, IAB 6/1/11, effective 5/12/11; **ARC 0824C**, IAB 7/10/13, effective 9/1/13]

441—79.17(249A) 2013 reimbursement rate increases. Rescinded **ARC 1056C**, IAB 10/2/13, effective 11/6/13.

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◊ Two or more ARCs

1 Effective date of 79.1(2) and 79.1(5)*"t"* delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.

2 Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.

3 Effective date of subrule 79.1(13) delayed until adjournment of the 1992 Sessions of the General Assembly by the Administrative Rules Review Committee at its meeting held July 12, 1991.

[4] Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

[5] At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

[6] Effective date of October 1, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held September 10, 2002. At its meeting held November 19, 2002, the Committee voted to delay the effective date until adjournment of the 2003 Session of the General Assembly.

[7] July 1, 2009, effective date of amendments to 79.1(1)*"d,"* 79.1(2), and 79.1(24)*"a"*(1) delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.

[8] See HJR 2008 of 2012 Session of the Eighty-fourth General Assembly regarding nullification of amendment to 79.1(7)*"b"* (ARC 9959B, IAB 1/11/12).

CHAPTER 83
MEDICAID WAIVER SERVICES

PREAMBLE

Medicaid waiver services are services provided to maintain persons in their own homes or communities who would otherwise require care in a medical institution, including support for persons to seek and maintain employment in the community. Provision of these services must be cost-effective. Services are limited to certain targeted client groups for whom a federal waiver has been requested and approved. Services provided through the waivers are not available to other Medicaid recipients as the services are beyond the scope of the Medicaid state plan.
[**ARC 2471C**, IAB 3/30/16, effective 5/4/16]

DIVISION I—HCBS HEALTH AND DISABILITY WAIVER SERVICES

441—83.1(249A) Definitions.

"Attorney in fact under a durable power of attorney for health care" means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Blind individual" means an individual who has a central visual acuity of 20/200 or less in the better eye with the use of corrective lens or visual field restriction to 20 degrees or less.

"Client participation" means the amount of the recipient income that the person must contribute to the cost of health and disability waiver services exclusive of medical vendor payments before Medicaid will participate.

"Deeming" means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

"Disabled person" means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months. A child under the age of 18 is considered disabled if the child suffers a medically determinable physical or mental impairment of comparable severity.

"Financial participation" means client participation and medical payments from a third party including veterans' aid and attendance.

"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one.

"Guardian" means a guardian appointed in probate court.

"Intermediate care facility for persons with an intellectual disability level of care" means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

"Intermittent homemaker service" means homemaker service provided from one to three hours a day for not more than four days per week.

"Intermittent respite service" means respite service provided from one to three times a week.

"Managed care organization" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

"Medical assessment" means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer's mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

"Medical institution" means a nursing facility or an intermediate care facility for persons with an intellectual disability which has been approved as a Medicaid vendor.

"Medical intervention" means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer's care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

"Medical monitoring" means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer's plan of care.

"Nursing facility level of care" means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member's capacity to live independently.

2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

"Service plan" means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

"Skilled nursing facility level of care" means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

a. A physician order for all skilled services.

b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

c. An individualized care plan that identifies support needs.

d. Confirmation that skilled services are provided to the member.

e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"Substantial gainful activity" means productive activities which add to the economic wealth, or produce goods or services to which the public attaches a monetary value.

"Third-party payments" means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.2(249A) Eligibility. To be eligible for health and disability waiver services, a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.2(1) *Eligibility criteria.*

a. The person must be under the age of 65 and blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department.

Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act.

b. The person must be ineligible for Supplemental Security Income (SSI) if the person is 21 years of age or older, except that persons who are receiving health and disability waiver services upon reaching the age of 21 may continue to be eligible regardless of SSI eligibility until they reach the age of 25.

c. Persons shall meet the eligibility requirements of the supplemental security income program except for the following:

(1) The person is under 18 years of age, unmarried and not the head of a household and is ineligible for supplemental security income because of the deeming of the parent's(s') income.

(2) The person is married and is ineligible for supplemental security income because of the deeming of the spouse's income or resources.

(3) The person is ineligible for supplemental security income due to excess income and the person's income does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

(4) The person is under 18 years of age and is ineligible for supplemental security income because of excess resources.

d. The person must be certified as being in need of nursing facility or skilled nursing facility level of care or as being in need of care in an intermediate care facility for persons with an intellectual disability, based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person's condition, and annually for reassessment of the person's level of care.

(2) The IME medical services unit shall be responsible for the initial determination of the member's level of care certification. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

(3) Health and disability waiver services will not be provided when the person is an inpatient in a medical institution.

(4) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

e. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician or a physician assistant.

f. The person must meet income and resource guidelines for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2)*"b"* and 75.5(4)*"c"* shall be applied.

g. The person must have service needs that can be met by this waiver program. At a minimum a person must receive one billable unit of service under the waiver per calendar quarter.

h. To be eligible for the consumer choices option as set forth in 441—subrule 78.34(13), a person cannot be living in a residential care facility.

83.2(2) *Need for services.*

a. The member shall have a service plan approved by the department which is developed by the service worker or targeted case manager identified by the county of residence. This service plan must be completed prior to services provision and annually thereafter.

The service worker or targeted case manager shall establish the interdisciplinary team for the member and, with the team, identify the member's need for service based on the member's needs and desires as well as the availability and appropriateness of services, using the following criteria:

(1) This service plan shall be based, in part, on information in the completed Service Worker Comprehensive Assessment, Form 470-5044. Form 470-5044 shall be completed annually. The service worker or targeted case manager shall have a face-to-face visit with the member at least annually.

(2) Service plans for persons aged 20 or under shall be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. The service worker or targeted case manager shall list all nonwaiver Medicaid services in the service plan.

(3) Service plans for persons aged 20 or under that include home health or nursing services shall not be approved until a home health agency has made a request to cover the member's service needs through nonwaiver Medicaid services.

b. Except as provided below, the total monthly cost of the health and disability waiver services, excluding the cost of home and vehicle modification services, shall not exceed the established aggregate monthly cost for level of care as follows:

Skilled level of care	Nursing level of care	ICF/ID
$2,792.65	$950.28	$3,742.93

For members eligible for SSI who remain eligible for health and disability waiver services until the age of 25 because they are receiving health and disability waiver services upon reaching the age of 21, these amounts shall be increased by the cost of services for which the member would be eligible under 441—subrule 78.9(10) if still under 21 years of age.

c. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker or targeted case manager. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)*"b"*(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1445C**, IAB 4/30/14, effective 7/1/14; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16]

441—83.3(249A) Application.

83.3(1) *Application for HCBS health and disability waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.3(2) *Application and services program limit.* The number of persons who may be approved for the HCBS health and disability waiver shall be subject to the number of members to be served as set forth in the federally approved HCBS health and disability waiver. The number of members to be served is set forth at the time of each five-year renewal of the waiver or in amendments to the waiver approved by the Centers for Medicare and Medicaid Services (CMS). When the number of applicants exceeds the number of members specified in the approved waiver, the applicant's name shall be placed on a waiting list maintained by the bureau of long-term care.

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the applicant.

(3) A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(4) Once a payment slot is assigned, the county department office shall give written notice to the applicant. The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the department shall enter persons on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later.

(2) Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date a request as specified in 83.3(2)*"a"*(2) is received by the department.

(3) In the event that more than one application is received at one time, persons shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(4) Applicants who do not fall within the available slots shall have their application rejected, and their names shall be maintained on the waiting list. They shall be contacted to reapply as slots become available based on their order on the waiting list so that the number of approved persons on the program is maintained. The bureau of long-term care shall contact the county department office when a slot becomes available.

(5) Once a payment slot is assigned, the county department office shall give written notice to the person within five working days. The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

c. The county department office shall notify the bureau of long-term care within five working days of the receipt of an application and of any action on or withdrawal of an application.

83.3(3) *Approval of application.*

a. Applications for the HCBS health and disability waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal supplemental security income benefits.

(2) The application is pending because the department has not received information which is beyond the control of the client or the department.

(3) The application is pending due to the disability determination process performed through the department.

(4) The application is pending because a level of care determination has not been made although the completed Form 470-4392, Level of Care Certification for HCBS Waiver Program, has been submitted to the IME medical services unit.

(5) The application is pending because the assessment, Form 470-4392, or the service plan has not been completed. When a determination is not completed 90 days from the date of application due to the lack of a completed assessment, Form 470-4392, or service plan, the application shall be denied.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations are completed.

c. An applicant must be given the choice between HCBS health and disability waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-5044, Service Worker Comprehensive Assessment, and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

e. A member may be enrolled in only one waiver program at a time. Costs for waiver services are not reimbursable while the member is in a medical institution (hospital or nursing facility) or residential facility. Services may not be simultaneously reimbursed for the same time period as Medicaid or other Medicaid waiver services.

83.3(4) *Effective date of eligibility.*

a. Deeming of parental or spousal income and resources ceases and eligibility shall be effective on the date the income and resource eligibility and level of care determinations are completed but shall not be earlier than the first of the month following the date of application.

b. The effective date of eligibility for the health and disability waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom paragraphs 83.3(4)*"a"* and *"c"* do not apply is the date on which the income eligibility and level of care determinations are completed.

c. Eligibility for persons covered under subparagraph 83.2(1)*"c"*(3) shall exist on the date the income and resource eligibility and level of care determinations are completed but shall not be earlier than the first of the month following the date of application.

d. Eligibility continues until the member has been in a medical institution for 30 consecutive days for other than respite care. Members who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be terminated from health and disability waiver services and reviewed for eligibility for other Medicaid coverage groups. The member will be notified of that decision through Form 470-0602, Notice of Decision. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.3(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.4(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of health and disability waiver services or other Medicaid services, as applicable.

83.4(1) *Maintenance needs of the individual.* The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.4(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker or targeted case manager for health and disability waiver services, Medicaid shall make no payments to health and disability waiver service providers. However, Medicaid shall make payments to other medical vendors, as applicable.

83.4(3) *Maintenance needs of spouse and other dependents.* Rescinded IAB 4/9/97, effective 6/1/97.

[**ARC 0757C**, IAB 5/29/13, effective 8/1/13]

441—83.5(249A) Redetermination. A complete redetermination of eligibility for the health and disability waiver shall be completed at least once every 12 months or when there is significant change in the person's situation or condition.

A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.2(249A). A redetermination shall include verification of the existence of a current service plan meeting the requirements listed in rule 441—83.7(249A).

83.5(1) The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

83.5(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[**ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.6(249A) Allowable services. Services allowable under the health and disability waiver are homemaker, home health, adult day care, respite care, nursing, counseling, consumer-directed attendant care, interim medical monitoring and treatment, home and vehicle modification, personal emergency response system, home-delivered meals, nutritional counseling, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.34(249A).

[**ARC 0757C**, IAB 5/29/13, effective 8/1/13]

441—83.7(249A) Service plan. A service plan shall be prepared for health and disability waiver members in accordance with 441—paragraph 90.5(1)*"b."* Service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

83.7(1) The service plan shall include the frequency of the health and disability waiver services and the types of providers who will deliver the services.

83.7(2) The service plan shall indicate whether the member has elected the consumer choices option. If the member has elected the consumer choices option, the service plan shall identify:

a. The independent support broker selected by the member; and

b. The financial management service selected by the member.

83.7(3) The service plan shall also list all nonwaiver Medicaid services.

83.7(4) The service plan shall identify a plan for emergencies and the supports available to the member in an emergency.

[**ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.8(249A) Adverse service actions.

83.8(1) Denial. An application for services shall be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Needed services are not available or received from qualified providers.

c. Service needs exceed the aggregate monthly costs established in 83.2(2)*"b,"* or are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

83.8(2) Termination. A particular service may be terminated when the department determines that:

a. The provisions of 441—paragraph 130.5(2)*"a," "b," "c," "g,"* or *"h"* apply.

b. The costs of the health and disability waiver service for the person exceed the aggregate monthly costs established in 83.2(2)*"b."*

c. The member receives care in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability for 30 days in any one stay for purposes other than respite care.

d. The member receives health and disability waiver services and the physical or mental condition of the member requires more care than can be provided in the member's own home as determined by the service worker or targeted case manager.

e. Service providers are not available.

83.8(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs *"a"* and *"b."*
[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0757C**, IAB 5/29/13, effective 8/1/13]

441—83.9(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234). The applicant or recipient is entitled to have a review of the level of care determination by the IME medical services unit by sending a letter requesting a review to the IME medical services unit. If dissatisfied with that decision, the applicant or recipient may file an appeal with the department.

441—83.10(249A) County reimbursement. Rescinded IAB 4/9/97, effective 6/1/97.

441—83.11(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.12 to **83.20** Reserved.

DIVISION II—HCBS ELDERLY WAIVER SERVICES

441—83.21(249A) Definitions.

"Attorney in fact under a durable power of attorney for health care" means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Client participation" means the amount of the recipient income that the person must contribute to the cost of elderly waiver services exclusive of medical vendor payments before Medicaid will participate.

"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one.

"Guardian" means a guardian appointed in probate court.

"Interdisciplinary team" means a collection of persons with varied professional backgrounds who develop one plan of care to meet a client's need for services.

"Managed care organization" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

"Medical institution" means a nursing facility which has been approved as a Medicaid vendor.

"Nursing facility level of care" means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member's capacity to live independently.
2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

"Service plan" means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

"Skilled nursing facility level of care" means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

a. A physician order for all skilled services.

b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

c. An individualized care plan that identifies support needs.

d. Confirmation that skilled services are provided to the member.

e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"Third-party payments" means payments from an individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[**ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.22(249A) Eligibility. To be eligible for elderly waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.22(1) *Eligibility criteria.* All of the following criteria must be met. The person must be:

a. Sixty-five years of age or older.

b. A resident of the state of Iowa.

c. Eligible for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2)*"b"* and 75.5(4)*"c"* shall be applied.

d. Certified as being in need of the intermediate or skilled level of care based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person's condition, and annually for reassessment of the person's level of care. The IME medical services unit shall be responsible for determination of the initial level of care.

(2) The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

(3) Elderly waiver services will not be provided when the person is an inpatient in a medical institution.

(4) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

e. Determined to need services as described in subrule 83.22(2).

f. Rescinded IAB 10/11/06, effective 10/1/06.

g. For the consumer choices option as set forth in rule 441—subrule 78.37(16), residing in a living arrangement other than a residential care facility.

83.22(2) *Need for services, service plan, and cost.*

a. Case management. Consumers under the elderly waiver shall receive case management services from a provider qualified pursuant to 441—subrule 77.33(21). Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. Interdisciplinary team. The case manager shall establish an interdisciplinary team for the consumer.

(1) Composition. The interdisciplinary team shall include the case manager and the consumer and, if appropriate, the consumer's legal representative, family, service providers, and others directly involved in the consumer's care.

(2) Role. The team shall identify:

1. The consumer's need for services based on the consumer's needs and desires.
2. Available and appropriate services to meet the consumer's needs.
3. Health and safety issues for the consumer that indicate the need for an emergency plan, based on a risk assessment conducted before the team meeting.
4. Emergency backup support and a crisis response system to address problems or issues arising when support services are interrupted or delayed or when the consumer's needs change.

c. Service plan. An applicant for elderly waiver services shall have a service plan developed by a qualified provider of case management services under the elderly waiver.

(1) Services included in the service plan shall be appropriate to the problems and specific needs or disabilities of the consumer.

(2) Services must be the least costly available to meet the service needs of the member. The total monthly cost of the elderly waiver services exclusive of case management services shall not exceed the established monthly cost of the level of care. Aggregate monthly costs, excluding the cost of case management and home and vehicle modifications, are limited as follows:

Skilled level of care	Nursing level of care
$2,792.65	$1,365.78

(3) The service plan must be completed before services are provided.

(4) The service plan must be reviewed at least annually and when there is any significant change in the consumer's needs.

d. Content of service plan. The service plan shall include the following information based on the consumer's current assessment and service needs:

(1) Observable or measurable individual goals.

(2) Interventions and supports needed to meet those goals.

(3) Incremental action steps, as appropriate.

(4) The names of staff, people, businesses, or organizations responsible for carrying out the interventions or supports.

(5) The desired individual outcomes.

(6) The identified activities to encourage the consumer to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan.

(7) Description of any restrictions on the consumer's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications.

(8) A list of all Medicaid and non-Medicaid services that the consumer received at the time of waiver program enrollment that includes:

1. The name of the service provider responsible for providing the service.
2. The funding source for the service.
3. The amount of service that the consumer is to receive.

(9) Indication of whether the consumer has elected the consumer choice option and, if so, the independent support broker and the financial management service that the consumer has selected.

(10) The determination that the services authorized in the service plan are the least costly.

(11) A plan for emergencies that identifies the supports available to the consumer in situations for which no approved service plan exists and which, if not addressed, may result in injury or harm to the consumer or other persons or in significant amounts of property damage. Emergency plans shall include:

1. The consumer's risk assessment and the health and safety issues identified by the consumer's interdisciplinary team.

2. The emergency backup support and crisis response system identified by the interdisciplinary team.

3. Emergency, backup staff designated by providers for applicable services.

83.22(3) *Providers—standards.* Rescinded IAB 10/11/06, effective 10/1/06.

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1445C**, IAB 4/30/14, effective 7/1/14; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16]

441—83.23(249A) Application.

83.23(1) *Application for HCBS elderly waiver.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.23(2) *Application for services.* Rescinded IAB 12/6/95, effective 2/1/96.

83.23(3) *Approval of application.*

a. Applications for the elderly waiver program shall be processed in 30 days unless the worker can document difficulty in locating and arranging services or circumstances beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant must be given the choice between elderly waiver services and institutional care. The applicant, guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-4694, Case Management Comprehensive Assessment, indicating that the applicant has elected waiver services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.23(4) *Effective date of eligibility.*

a. The effective date of eligibility is the date on which the income eligibility and level of care determinations are completed.

b. Eligibility for persons whose income exceeds supplemental security income guidelines shall not exist until the persons require care in a medical institution for a period of 30 consecutive days and shall be effective no earlier than the first day of the month in which the 30-day period begins.

c. Eligibility continues until the consumer has been in a medical institution for 30 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.22(249A). Consumers who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be terminated from elderly waiver services and reviewed for eligibility for other Medicaid coverage groups. The consumer will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.23(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.24(249A) Client participation. Persons must contribute their predetermined client participation to the cost of elderly waiver services.

83.24(1) *Computation of client participation.* Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.24(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker, Medicaid will make no payments for elderly waiver service providers. However, Medicaid will make payments to other medical vendors.

441—83.25(249A) Redetermination. A complete redetermination of eligibility for elderly waiver services shall be done at least once every 12 months.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.22(249A). A redetermination shall contain the components listed in rule 441—83.27(249A).

83.25(1) The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

83.25(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[**ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.26(249A) Allowable services. Services allowable under the elderly waiver are case management, adult day care, emergency response system, homemaker, home health aide, nursing, respite care, chore, home-delivered meals, home and vehicle modification, mental health outreach, transportation, nutritional counseling, assistive devices, senior companions, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.37(249A).

441—83.27(249A) Service plan. The service plan shall be completed jointly by the consumer, the elderly waiver case manager, and any other person identified by the consumer.

83.27(1) The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

a. The independent support broker selected by the consumer; and

b. The financial management service selected by the consumer.

83.27(2) The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

441—83.28(249A) Adverse service actions.

83.28(1) *Denial.* An application for services shall be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Except for respite care, the elderly waiver services are not needed on a regular basis.

c. Service needs exceed the aggregate monthly costs established in 83.22(2)*"b,"* or are not met by services provided.

d. Needed services are not available or received from qualifying providers.

e. Rescinded IAB 3/2/94, effective 3/1/94.

83.28(2) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"a," "b," "c," "d," "g,"* or *"h"* apply.

b. The costs of the elderly waiver services for the person exceed the aggregate monthly costs established in 83.22(2)*"b."*

c. The client receives care in a hospital or nursing facility for 30 days in any one stay for purposes other than respite care.

d. The client receives elderly waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the case manager and the interdisciplinary team.

e. Service providers are not available.

83.28(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs *"a"* and *"b."*

441—83.29(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).
[**ARC 0306C**, IAB 9/5/12, effective 11/1/12]

441—83.30(249A) Enhanced services. When a household has one person receiving service in accordance with rules set forth in 441—Chapter 24 and another receiving elderly waiver services, the persons providing case management shall cooperate to make the best plan for both clients. When a person is eligible for services as set forth in 441—Chapter 24 and eligible for services under the elderly waiver, the person's primary diagnosis will determine which services shall be used.

441—83.31(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.32 to **83.40** Reserved.

DIVISION III—HCBS AIDS/HIV WAIVER SERVICES

441—83.41(249A) Definitions.

"AIDS" means a medical diagnosis of acquired immunodeficiency syndrome based on the Centers for Disease Control "Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome," August 14, 1987, Vol. 36, No. 1S issue of "Morbidity and Mortality Weekly Report."

"Attorney in fact under a durable power of attorney for health care" means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Client participation" means the amount of the recipient's income that the person must contribute to the cost of AIDS/HIV waiver services exclusive of medical vendor payments before Medicaid will participate.

"Deeming" means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

"Financial participation" means client participation and medical payments from a third party including veterans' aid and attendance.

"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one.

"Guardian" means a guardian appointed in probate court.

"HIV" means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

"Managed care organization" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

"Medical institution" means a nursing facility or hospital which has been approved as a Medicaid vendor.

"Nursing facility level of care" means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member's capacity to live independently.

2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

"Service plan" means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

"Skilled nursing facility level of care" means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

a. A physician order for all skilled services.

b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

c. An individualized care plan that identifies support needs.

d. Confirmation that skilled services are provided to the member.

e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"Third-party payments" means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[**ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.42(249A) Eligibility. To be eligible for AIDS/HIV waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.42(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Be diagnosed by a physician as having AIDS or HIV infection.

b. Be certified in need of the level of care that, but for the waiver, would otherwise be provided in a nursing facility or hospital based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person's condition, and annually for reassessment of the person's level of care.

(2) The IME medical services unit shall be responsible for approval of the certification of the level of care, and the IME medical services unit or a managed care organization will be responsible for annual redeterminations.

(3) AIDS/HIV waiver services shall not be provided when the person is an inpatient in a medical institution.

c. Be eligible for medical assistance under SSI, SSI-related, FMAP, or FMAP-related coverage groups; medically needy at hospital level of care; or a special income level (300 percent group); or become eligible through application of the institutional deeming rules.

d. Require, and use at least quarterly, one service available under the waiver as determined through an evaluation of need described in subrule 83.42(2).

e. Have service needs such that the costs of the waiver services are not likely to exceed the costs of care that would otherwise be provided in a medical institution.

f. Have income which does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

g. For the consumer choices option as set forth in 441—subrule 78.38(9), not be living in a residential care facility.

83.42(2) *Need for services.*

a. The department service worker shall perform an assessment of the person's need for waiver services and determine the availability and appropriateness of services. This assessment shall be based, in part, on information in the completed Service Worker Comprehensive Assessment, Form 470-5044. Form 470-5044 shall be completed annually.

b. The total monthly cost of the AIDS/HIV waiver services shall not exceed the established aggregate monthly cost for level of care. The monthly cost of AIDS/HIV waiver services cannot exceed the established limit of $1,876.80.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16]

441—83.43(249A) Application.

83.43(1) *Application for HCBS AIDS/HIV waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.43(2) *Application for services.* Rescinded IAB 12/6/95, effective 2/1/96.

83.43(3) *Approval of application.*

a. Applications for the HCBS AIDS/HIV waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) The application is pending because the department has not received information, which is beyond the control of the client or the department.

(2) The application is pending because a level of care determination has not been made although the completed Form 470-4392, Level of Care Certification for HCBS Waiver Program, has been submitted to the IME medical services unit.

(3) Rescinded IAB 3/7/01, effective 5/1/01.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the consumer service plan are completed.

c. An applicant must be given the choice between HCBS AIDS/HIV waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-5044, Service Worker Comprehensive Assessment, and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.43(4) *Effective date of eligibility.*

a. The effective date of eligibility for the AIDS/HIV waiver for persons who are already determined eligible for Medicaid is the date on which the income and resource eligibility and level of care determinations are completed.

b. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom 441—subrule 75.1(7) and rule 441—75.5(249A) do not apply is the date on which income and resource eligibility and level of care determinations are completed.

c. Eligibility for the waiver continues until the recipient has been in a medical institution for 30 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.42(249A). Recipients who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be reviewed for eligibility for other Medicaid coverage groups and terminated from AIDS/HIV waiver services if found eligible under another coverage group. The

recipient will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the person's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

d. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A) have been satisfied is the date on which the income eligibility and level of care determinations are completed but shall not be earlier than the first of the month following the date of application.

83.43(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.44(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of AIDS/HIV waiver services or other Medicaid services, as applicable.

83.44(1) *Maintenance needs of the individual.* The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.44(2) *Limitation on payment.* If the amount of the financial participation equals or exceeds the reimbursement established by the service worker for AIDS/HIV services, Medicaid will make no payments to AIDS/HIV waiver service providers. Medicaid will, however, make payments to other medical vendors.

83.44(3) *Maintenance needs of spouse and other dependents.* Rescinded IAB 4/9/97, effective 6/1/97.

441—83.45(249A) Redetermination. A complete redetermination of eligibility for AIDS/HIV waiver services shall be completed at least once every 12 months or when there is significant change in the person's situation or condition. A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.42(249A). A redetermination shall include the components listed in rule 441—83.47(249A).

83.45(1) The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

83.45(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[**ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.46(249A) Allowable services. Services allowable under the AIDS/HIV waiver are counseling, home health aide, homemaker, nursing care, respite care, home-delivered meals, adult day care, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.38(249A).

441—83.47(249A) Service plan. A service plan shall be prepared for AIDS/HIV waiver consumers in accordance with rule 441—130.7(234) except that service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

83.47(1) The service plan shall include the frequency of the AIDS/HIV waiver services and the types of providers who will deliver the services.

83.47(2) The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

a. The independent support broker selected by the consumer; and

b. The financial management service selected by the consumer.

83.47(3) Service plans for consumers aged 20 or under must be developed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

83.47(4) The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

441—83.48(249A) Adverse service actions.

83.48(1) Denial. An application for services shall be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Except for respite care, the AIDS/HIV waiver services are not needed on a regular basis.

c. Service needs exceed the aggregate monthly costs established in 83.42(2)*"b"* or cannot be met by the services provided under the waiver.

d. Needed services are not available from qualified providers.

83.48(2) Termination. Participation in the AIDS/HIV waiver program may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"a," "b," "c," "d," "g,"* or *"h"* apply.

b. The costs of the AIDS/HIV waiver services for the person exceed the aggregate monthly costs established in 83.42(2)*"b."*

c. The client receives care in a hospital or nursing facility for 30 days or more in any one stay for purposes other than respite care.

d. The client receives AIDS/HIV waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the service worker.

e. Service providers are not available.

83.48(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs *"a"* and *"b."*

441—83.49(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).
[**ARC 0306C**, IAB 9/5/12, effective 11/1/12]

441—83.50(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code section 249A.4.

441—83.51 to **83.59** Reserved.

DIVISION IV—HCBS INTELLECTUAL DISABILITY WAIVER SERVICES

441—83.60(249A) Definitions.

"Adaptive" means age-appropriate skills related to taking care of one's self and one's ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home-living, social skills, community use, self-direction, safety, functional activities of daily living, leisure or work.

"Adult" means a person with an intellectual disability aged 18 or over.

"Appropriate" means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

"Attorney in fact under a durable power of attorney for health care" means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Behavior" means skills related to regulating one's own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

"Case management services" means those services established pursuant to Iowa Code chapter 225C.

"Child" means a person with an intellectual disability aged 17 or under.

"Client participation" means the posteligibility amount of the consumer's income that persons eligible through a special income level must contribute to the cost of the home and community-based waiver service.

"Counseling" means face-to-face mental health services provided to the consumer and caregiver by a qualified intellectual disability professional (QIDP) to facilitate home management of the consumer and prevent institutionalization.

"Deemed status" means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

"Department" means the Iowa department of human services.

"Direct service" means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

"Fiscal accountability" means the development and maintenance of budgets and independent fiscal review.

"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one.

"Guardian" means a guardian appointed in probate court.

"Health" means skills related to the maintenance of one's health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

"Immediate jeopardy" means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

"Intellectual disability" means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder) which shall be made only when the onset of the person's condition was during the developmental period and shall be based on an assessment of the person's intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a licensed psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person's adaptive skills. The diagnosis shall be made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), published by the American Psychiatric Association.

"Intermediate care facility for persons with an intellectual disability (ICF/ID)" means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

"Intermediate care facility for persons with an intellectual disability level of care" means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

"Intermittent supported community living service" means supported community living service provided not more than 52 hours per month.

"Maintenance needs" means costs associated with rent or mortgage, utilities, telephone, food and household supplies.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

"Managed care organization" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

"Medical assessment" means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer's mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

"Medical institution" means a nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

"Medical intervention" means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer's care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

"Medical monitoring" means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer's plan of care.

"Natural supports" means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

"Organization" means the entity being certified.

"Organizational outcome" means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

"Outcome" means an action or event that follows as a result or consequence of the provision of a service or support.

"Procedures" means the steps to be taken to implement a policy.

"Process" means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

"Qualified intellectual disability professional" means a person who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and who is one of the following:

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. An occupational therapist eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.
4. A physical therapist eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.
5. A speech-language pathologist or audiologist eligible for certification of Clinical Competence in Speech-Language Pathology or Audiology by the American Speech-Language Hearing Association or another comparable body or who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification.
6. A psychologist with a master's degree in psychology from an accredited school.

7. A social worker with a graduate degree from a school of social work, accredited or approved by the Council on Social Work Education or another comparable body or who holds a bachelor of social work degree from a college or university accredited or approved by the Council of Social Work Education or another comparable body.

8. A professional recreation staff member with a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education.

9. A professional dietitian who is eligible for registration by the American Dietetics Association.

10. A human services professional who must have at least a bachelor's degree in a human services field including, but not limited to, sociology, special education, rehabilitation counseling and psychology.

"Related condition" means a severe, chronic disability that meets all the following conditions:

1. It is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual disability and requires treatment or services similar to those required for a person with an intellectual disability.

2. It is manifested before the age of 22.

3. It is likely to continue indefinitely.

4. It results in substantial functional limitations in three or more of the following areas of major life activity:

- Self-care.
- Understanding and use of language.
- Learning.
- Mobility.
- Self-direction.
- Capacity for independent living.

"Service plan" means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

"SIS assessment" means the Supports Intensity Scale® assessment developed and licensed by the American Association on Intellectual and Developmental Disabilities for use in the assessment of the support and service needs of individuals.

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"Staff" means a person under the direction of the organization to perform duties and responsibilities of the organization.

"Third-party payments" means payments from an attorney, individual, institution, corporation, insurance company, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of Medicaid.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[**ARC 9650B**, IAB 8/10/11, effective 10/1/11; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 2050C**, IAB 7/8/15, effective 7/1/15; **ARC 2168C**, IAB 9/30/15, effective 11/4/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.61(249A) Eligibility. To be eligible for HCBS intellectual disability waiver services a person must meet certain eligibility criteria and be determined to need a service(s) available under the program.

83.61(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Have a diagnosis of intellectual disability as defined in rule 441—83.60(249A). The diagnosis shall be initially established and recertified as follows:

Age	Initial application to HCBS intellectual disability waiver program	Recertification for persons with a diagnosis of moderate, severe or profound level of severity	Recertification for persons with a diagnosis of mild or unspecified level of severity
0 through 17 years	Psychological documentation within three years of the application date substantiating a diagnosis of intellectual disability as defined in rule 441—83.60(249A)	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every six years and when a significant change occurs	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every three years and when a significant change occurs
18 years and above	Current psychological documentation substantiating a diagnosis of intellectual disability if the last testing date was (1) more than six years ago for an applicant with a diagnosis of mild or unspecified severity, or (2) more than ten years ago for an applicant with a diagnosis of moderate, severe or profound level of severity	Psychological documentation substantiating a diagnosis of intellectual disability made since the member reached 22 years of age	Psychological documentation substantiating a diagnosis of intellectual disability every six years and whenever a significant change occurs

b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups; eligible under the special income level (300 percent) coverage group; or become eligible through application of the institutional deeming rules or would be eligible for Medicaid if in a medical institution.

c. Be certified as being in need for long-term care that, but for the waiver, would otherwise be provided in an ICF/ID. The IME medical services unit shall be responsible for the initial approval, and the IME medical services unit or a managed care organization will be responsible for the annual approval of the certification of the level of care based on the data collected by the case manager and interdisciplinary team on a tool designated by the department.

d. Be a recipient of the Medicaid case management services or be identified to receive Medicaid case management services immediately following program enrollment.

e. Have service needs that can be met by this waiver program. At a minimum, a consumer must receive one billable unit of service per calendar quarter under this program.

f. Have a service plan completed annually and approved by the department in accordance with rule 441—83.67(249A).

g. For individual supported employment and long-term job coaching services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Not reside in a medical institution.

(4) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

h. For small-group supported employment services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

(5) Not reside in a medical institution.

i. For prevocational services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

(5) Not reside in a medical institution.

j. Choose HCBS intellectual disability waiver services rather than ICF/ID services.

k. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician.

l. Be assigned an HCBS intellectual disability payment slot pursuant to subrule 83.61(4).

m. For residential-based supported community living services, meet all of the following additional criteria:

(1) Be less than 18 years of age.

(2) Be preapproved as appropriate for residential-based supported community living services by the bureau of long-term care. Requests for approval shall be submitted in writing to the DHS Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, and shall include the following:

1. Social history;

2. Case history that includes previous placements and service programs;

3. Medical history that includes major illnesses and current medications;

4. Current psychological evaluations and consultations;

5. Summary of all reasonable and appropriate service alternatives that have been tried or considered;

6. Any current court orders in effect regarding the child;

7. Any legal history;

8. Whether the child is at risk of out-of-home placement or the proposed placement would be less restrictive than the child's current placement for services;

9. Whether the proposed placement would be safe for the child and for other children living in that setting; and

10. Whether the interdisciplinary team is in agreement with the proposed placement.

(3) Either:

1. Be residing in an ICF/ID;

2. Be at risk of ICF/ID placement, as documented by an interdisciplinary team assessment pursuant to paragraph 83.61(2)*"a"*; or

3. Be a child whose long-term placement outside the home is necessary because continued stay in the home would be a detriment to the health and welfare of the child or the family, and all service options to keep the child in the home have been reviewed by an interdisciplinary team, as documented in the service file.

n. For day habilitation, be 16 years of age or older.

o. For the consumer choices option as set forth in 441—subrule 78.41(5), not be living in a residential care facility.

83.61(2) *Need for services.*

a. Applicants currently receiving Medicaid case management shall have the applicable staff coordinate with the department to arrange an SIS assessment.

b. Applicants not receiving services as set forth in paragraph 83.61(2)*"a"* shall have a department service worker or case manager:

(1) Arrange an SIS assessment for the initial level of care determination;

(2) Establish an initial interdisciplinary team for HCBS intellectual disability waiver services; and

(3) With the initial interdisciplinary team, identify the applicant's needs and desires as well as the availability and appropriateness of services.

c. Applicants meeting other eligibility criteria who do not have a Medicaid case manager shall be referred to a Medicaid case manager.

d. Services shall not exceed the number of maximum units established for each service.

e. The cost of services shall not exceed unit expense maximums. Requests shall only be reviewed for funding needs exceeding the supported community living service unit cost maximum. Requests require special review by the department and may be denied as not cost-effective.

f. The case manager shall coordinate with the department to arrange an SIS assessment for the initial level of care determination within 30 days from the date of the HCBS application unless the worker can document difficulty in locating information necessary to arrange the SIS assessment or other circumstances beyond the worker's control.

g. At initial enrollment, the case manager shall establish an interdisciplinary team for each applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services. The Medicaid case manager shall complete an annual review thereafter. The following criteria shall be used for the initial and ongoing identification of need for services:

(1) The assessment shall be based on the results of the most recent SIS assessment or of the SIS contractor's off-year review.

(2) Service plans must be developed or reviewed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall be approved (signed and dated) by the designee of the bureau of long-term care. The service worker, department QIDP, or Medicaid case manager shall attach a written request for a variance from the maximum for intermittent supported community living with a summary of services and service costs. The written request for the variance shall provide a rationale for requesting supported community living beyond intermittent. The rationale shall contain sufficient information for the designee to make a decision regarding the need for supported community living beyond intermittent.

h. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)*"b"*(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

83.61(3) *HCBS intellectual disability waiver program limit.* The number of persons receiving HCBS intellectual disability waiver services in the state shall be limited to the number of payment slots provided in the HCBS intellectual disability waiver approved by the Centers for Medicare and Medicaid Services (CMS). The department shall make a request to CMS to adjust the program limit as deemed necessary.

a. The payment slots are available on a statewide basis. These slots shall be available based on the prioritized need of an applicant pursuant to subrule 83.61(4).

b. When services are denied because the limit is reached, a notice of decision denying service based on the limit and stating that the person's name will be put on a waiting list shall be sent to the person by the department.

83.61(4) *Securing a payment slot.* The department shall determine if a payment slot is available for each applicant for the HCBS intellectual disability waiver.

a. A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(1) Once a payment slot is assigned, the department shall give written notice to the applicant.

(2) The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the applicant shall be placed on a statewide priority waiting list. The department shall assess each applicant to determine the applicant's priority need. The assessment shall be made for all applicants who are on a waiting list maintained by the state or a county on September 30, 2011, and for all new applications received on or after October 1, 2011.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.

2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.

3. The applicant is living in a homeless shelter and no alternative housing options are available.

4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.

5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.

2. The caregiver will be unable to continue to provide care within the next 60 days.

3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.

4. The applicant is living in temporary housing and plans to move within 31 to 120 days.

5. The applicant is losing permanent housing and plans to move within 31 to 120 days.

6. The caregiver will be unable to be employed if services are not available.

7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.

8. The applicant has behaviors that put the applicant at risk.

9. The applicant has behaviors that put others at risk.

10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion shall be placed on the priority waiting list based on the total number of criteria in subparagraph 83.61(4)*"b"*(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion shall be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list shall be based on the total number of criteria in subparagraph 83.61(4)*"b"*(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria shall be placed lower on the waiting list than the applicants meeting urgent need criteria, based on the date of application. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(6) Applicants shall remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant's need, the applicant may contact the local department office and request that a new assessment be completed. The outcome of the assessment shall determine placement on the waiting list as directed in this subrule.

c. To maintain the approved number of members in the program, persons shall be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department shall give written notice to the person within five working days.

(2) The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

[**ARC 9650B**, IAB 8/10/11, effective 10/1/11; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 2050C**, IAB 7/8/15, effective 7/1/15; **ARC 2168C**, IAB 9/30/15, effective 11/4/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 2471C**, IAB 3/30/16, effective 5/4/16]

441—83.62(249A) Application.

83.62(1) *Application for HCBS intellectual disability waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.62(2) Rescinded IAB 6/5/96, effective 8/1/96.

83.62(3) *Approval of application.*

a. Applications for the HCBS intellectual disability waiver program shall be processed in 30 days unless the case manager or worker can document difficulty in locating and arranging services or other circumstance beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant shall be given the choice between HCBS waiver services and ICF/ID care. The case manager or worker shall have the consumer or legal representative indicate the consumer's choice of care.

d. HCBS intellectual disability waiver services provided before eligibility for the waiver is approved shall not be reimbursed by the HCBS waiver program.

e. Services provided when the person is a consumer of group foster care services or is an inpatient in a medical institution shall not be reimbursed.

f. HCBS intellectual disability waiver services are not available in conjunction with other Medicaid waiver services or group foster care services.

g. Rescinded IAB 5/6/09, effective 7/1/09.

83.62(4) *Effective date of eligibility.*

a. Deeming of parental income and resources ceases the month following the month in which a person requires care in a medical institution.

b. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet the criteria set forth in rule 441—83.61(249A).

c. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet criteria set forth in rule 441—83.61(249A) and when the eligibility factor set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A) have been satisfied.

d. Eligibility continues until the consumer fails to meet eligibility criteria listed in rule 441—83.61(249A). Consumers who are inpatients in a medical institution for 30 consecutive days shall receive a review by the interdisciplinary team to determine additional inpatient needs for possible termination from the HCBS program. Consumers shall be reviewed for eligibility under other Medicaid coverage groups. The consumer or legal representative shall participate in the review and receive formal notification of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's needs can still be met by the HCBS waiver services, the denial may be rescinded and eligibility may continue.

e. Eligibility and service reimbursement are effective through the last day of the month of the previous annual service plan staffing meeting and the corresponding long-term care need determination.

83.62(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 9650B**, IAB 8/10/11, effective 10/1/11; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 2168C**, IAB 9/30/15, effective 11/4/15]

441—83.63(249A) Client participation. Persons who are eligible under the 300 percent group must contribute a predetermined client participation amount to the costs of the services.

83.63(1) *Computation of client participation.* Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.63(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific HCBS waiver service, Medicaid will make no payments for the HCBS waiver service. However, Medicaid will make payments to other medical vendors.

441—83.64(249A) Redetermination. A redetermination of nonfinancial eligibility for HCBS intellectual disability waiver services shall be completed at least once every 12 months. In years in which an SIS assessment is not completed, the SIS contractor shall conduct a review in collaboration with the case manager, documenting any changes in the member's functional status since the previous SIS or other full assessment.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.61(249A).

83.64(1) The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

83.64(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[**ARC 9650B**, IAB 8/10/11, effective 10/1/11; **ARC 2168C**, IAB 9/30/15, effective 11/4/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.65(249A) Rescinded IAB 6/5/96, effective 8/1/96.

441—83.66(249A) Allowable services. Services allowable under the HCBS intellectual disability waiver are supported community living, respite, personal emergency response system, nursing, home health aide, home and vehicle modification, supported employment, consumer-directed attendant care, interim medical monitoring and treatment, transportation, adult day care, day habilitation, prevocational services, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.41(249A).
[**ARC 9650B**, IAB 8/10/11, effective 10/1/11]

441—83.67(249A) Service plan. A service plan shall be prepared for each HCBS intellectual disability waiver consumer.

83.67(1) *Development.* The service plan shall be developed by the interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager or service worker, service providers, and others directly involved.

83.67(2) *Retention.* The service plan shall be stored by the case manager for a minimum of three years.

83.67(3) *Interdisciplinary team meeting.* The interdisciplinary team meeting shall be conducted before the current service plan expires.

83.67(4) *Information in plan.* The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

a. A listing of all services received by a consumer at the time of waiver program enrollment.

b. For supported community living:

(1) The consumer's living environment at the time of waiver enrollment.

(2) The number of hours per day of on-site staff supervision needed by the consumer.

(3) The number of other waiver consumers who will live with the consumer in the living unit.

c. An identification and justification of any restriction of the consumer's rights including, but not limited to:

(1) Maintenance of personal funds.

(2) Self-administration of medications.

d. The name of the service provider responsible for providing each service.

e. The service funding source.

f. The amount of the service to be received by the consumer.

g. Whether the consumer has elected the consumer choices option and, if so:

(1) The independent support broker selected by the consumer; and

(2) The financial management service selected by the consumer.

h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.67(5) *Documentation.* The Medicaid case manager shall ensure that the consumer's case file contains the consumer's service plan and documentation supporting the diagnosis of mental retardation.

83.67(6) *Approval of plan.* The plan shall be approved through the Individualized Services Information System (ISIS). Services shall be entered into ISIS based on the service plan.

a. Services must be authorized and entered into ISIS before the plan implementation date.

b. The department has 15 working days after receipt of the summary and service costs in which to approve the services and service cost or request modification of the service plan unless the parties mutually agree to extend that time frame.

c. If the department and the service worker or case manager are unable to agree on the terms of the services or service cost within 10 days, the department has final authority regarding the services and service cost.
[**ARC 9650B**, IAB 8/10/11, effective 10/1/11; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12]

441—83.68(249A) Adverse service actions.

83.68(1) *Denial.* An application for services shall be denied when it is determined by the department that:

a. The applicant is not eligible for the services.

b. Service needs exceed the service unit or reimbursement maximums.

c. Service needs are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

e. No HCBS intellectual disability waiver service is identified in the applicant's service plan.

f. There is another community resource available to provide the service or a similar service free of charge to the applicant that will meet the applicant's needs.

g. Completion or receipt of required documents by the department for the HCBS program applicant has not occurred.

83.68(2) *Reduction.* A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph *"a"* or *"b,"* apply.

83.68(3) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2) paragraph *"d,""g,"* or *"h,"*, apply.

b. Needed services are not available or received from qualifying providers.

c. No HCBS intellectual disability waiver service is identified in the member's annual service plan.

d. Service needs are not met by the services provided.

e. Services needed exceed the service unit or reimbursement maximums.

f. Completion or receipt of required documents by the department for the HCBS program consumer has not occurred.

g. The consumer receives services from other Medicaid waiver programs.

h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

[**ARC 9650B**, IAB 8/10/11, effective 10/1/11]

441—83.69(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[**ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12]

441—83.70(249A) County reimbursement. Rescinded **ARC 0191C**, IAB 7/11/12, effective 7/1/12.

441—83.71(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

441—83.72(249A) Rent subsidy program. Members in the HCBS intellectual disability waiver program may be eligible for a rent subsidy. See 265—Chapter 24.

[**ARC 9650B**, IAB 8/10/11, effective 10/1/11]

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.73 to **83.80** Reserved.

DIVISION V—BRAIN INJURY WAIVER SERVICES

441—83.81(249A) Definitions.

"Adaptive" means age appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

"Adult" means a person with a brain injury aged 18 years or over.

"Appropriate" means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

"Assessment" means the review of the consumer's current functioning in regard to the consumer's situation, needs, strengths, abilities, desires and goals.

"Attorney in fact under a durable power of attorney for health care" means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Behavior" means skills related to regulating one's own behavior including coping with demands from others, making choices, conforming conduct to laws, and displaying appropriate sociosexual behavior.

"Brain injury" means clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, which temporarily or permanently impairs a person's physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:

Malignant neoplasms of brain, cerebrum.

Malignant neoplasms of brain, frontal lobe.

Malignant neoplasms of brain, temporal lobe.

Malignant neoplasms of brain, parietal lobe.

Malignant neoplasms of brain, occipital lobe.

Malignant neoplasms of brain, ventricles.

Malignant neoplasms of brain, cerebellum.

Malignant neoplasms of brain, brain stem.

Malignant neoplasms of brain, other part of brain, includes midbrain, peduncle, and medulla oblongata.

Malignant neoplasms of brain, cerebral meninges.

Malignant neoplasms of brain, cranial nerves.

Secondary malignant neoplasm of brain.

Secondary malignant neoplasm of other parts of the nervous system, includes cerebral meninges.

Benign neoplasm of brain and other parts of the nervous system, brain.

Benign neoplasm of brain and other parts of the nervous system, cranial nerves.

Benign neoplasm of brain and other parts of the nervous system, cerebral meninges.

Encephalitis, myelitis and encephalomyelitis.

Intracranial and intraspinal abscess.

Anoxic brain damage.

Subarachnoid hemorrhage.

Intracerebral hemorrhage.

Other and unspecified intracranial hemorrhage.

Occlusion and stenosis of precerebral arteries.

Occlusion of cerebral arteries.

Transient cerebral ischemia.

Acute, but ill-defined, cerebrovascular disease.

Other and ill-defined cerebrovascular diseases.

Fracture of vault of skull.

Fracture of base of skull.

Other and unqualified skull fractures.

Multiple fractures involving skull or face with other bones.

Concussion.

Cerebral laceration and contusion.

Subarachnoid, subdural, and extradural hemorrhage following injury.

Other and unspecified intracranial hemorrhage following injury.

Intracranial injury of other and unspecified nature.
Poisoning by drugs, medicinal and biological substances.
Toxic effects of substances.
Effects of external causes.
Drowning and nonfatal submersion.
Asphyxiation and strangulation.
Child maltreatment syndrome.
Adult maltreatment syndrome.

"Case management services" means those services established pursuant to Iowa Code chapter 225C.

"Child" means a person with a brain injury aged 17 years or under.

"Client participation" means the amount of the consumer's income that the person must contribute to the cost of brain injury waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

"Deemed status" means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

"Department" means the Iowa department of human services.

"Direct service" means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

"Fiscal accountability" means the development and maintenance of budgets and independent fiscal review.

"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one.

"Guardian" means a guardian appointed in probate court.

"Health" means skills related to the maintenance of one's health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

"Immediate jeopardy" means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

"Intermediate care facility for persons with an intellectual disability level of care" means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

"Intermittent supported community living service" means supported community living service provided from one to three hours a day for not more than four days a week.

"Managed care organization" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

"Medical assessment" means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer's mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

"Medical institution" means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

"Medical intervention" means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer's care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

"Medical monitoring" means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer's plan of care.

"Natural supports" means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

"Nursing facility level of care" means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member's capacity to live independently.

2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

"Organization" means the entity being certified.

"Organizational outcome" means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

"Outcome" means an action or event that follows as a result or consequence of the provision of a service or support.

"Procedures" means the steps to be taken to implement a policy.

"Process" means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

"Qualified brain injury professional" means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two years' experience working with people living with a brain injury: a psychologist; psychiatrist; physician; physician assistant; registered nurse; certified teacher; social worker; mental health counselor; physical, occupational, recreational, or speech therapist; or a person with a bachelor of arts or science degree in psychology, sociology, or public health or rehabilitation services.

"Service coordination" means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

"Service plan" means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

"Skilled nursing facility level of care" means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

a. A physician order for all skilled services.

b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

c. An individualized care plan that identifies support needs.

d. Confirmation that skilled services are provided to the member.

e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"Staff" means a person under the direction of the organization to perform duties and responsibilities of the organization.

"Third-party payments" means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.82(249A) Eligibility. To be eligible for brain injury waiver services a consumer must meet eligibility criteria and be determined to need a service allowable under the program.

83.82(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Have a diagnosis of brain injury.

b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups or be eligible under the special income level (300 percent) coverage group consistent with a level of care in a medical institution.

c. Be at least one month of age.

d. Be a U.S. citizen and Iowa resident.

e. Rescinded IAB 7/11/01, effective 7/1/01.

f. Be determined by the IME medical services unit as in need of intermediate care facility for persons with an intellectual disability (ICF/ID), skilled nursing, or ICF level of care.

g. Be assessed by the IME medical services unit as able to live in a home- or community-based setting where all medically necessary service needs can be met within the scope of this waiver.

h. At a minimum, receive a waiver service each quarter in addition to case management.

i. Choose HCBS.

j. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician.

k. Receive services in a community, not an institutional, setting.

l. Be assigned a state payment slot within the yearly total approved by the Centers for Medicare and Medicaid Services.

m. For the consumer choices option as set forth in rule 441—subrule 78.43(15), not be living in a residential care facility.

n. For individual supported employment and long-term job coaching services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Not reside in a medical institution.

(4) Have documented in the waiver service plan a goal to achieve or to sustain individual employment and an expectation that this service will result in this outcome.

o. For small-group supported employment services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

(5) Not reside in a medical institution.

p. For prevocational services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment and an expectation that this service will result in community employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive prevocational services was made.

83.82(2) *Need for services.*

a. The applicant shall have a service plan approved by the department that is developed by the certified case manager for this waiver as identified by the county of residence. This must be completed before services provision and annually thereafter. The case manager shall establish the interdisciplinary team for the applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services using the following criteria:

(1) The assessment shall be based, in part, on information provided to the IME medical services unit.

(2) Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid state services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall not be approved until a home health provider has made a request to cover the service through all nonwaiver Medicaid services.

(4) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager must request in writing more than intermittent supported community living with a summary of services and service costs, and submit a written justification with the service plan. The rationale must contain sufficient information for the bureau's designee to make a decision regarding the need for supported community living beyond intermittent.

b. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)*"b"*(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

c. The consumer shall access, if a child, all other services for which the person is eligible and which are appropriate to meet the person's needs as a precondition of eligibility for the HCBS BI waiver.

d. The total cost of brain injury waiver services, excluding the cost of case management and home and vehicle modifications, shall not exceed $3,013.08 per month.

83.82(3) *HCBS brain injury (BI) waiver program limit for persons requiring the ICF/MR level of care.* Rescinded IAB 7/11/01, effective 7/1/01.

83.82(4) *Securing a state payment slot.*

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available for all new applicants for the HCBS BI waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no payment slot is available, the department shall enter the applicant on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date the applicant requests HCBS BI program services.

(2) In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

c. Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

[**ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1445C**, IAB 4/30/14, effective 7/1/14; **ARC 2471C**, IAB 3/30/16, effective 5/4/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16]

441—83.83(249A) Application.

83.83(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.83(2) *Approval of application for eligibility.*

a. Applications for the determination of ability of the consumer to have all medically necessary service needs met within the scope of this waiver shall be initiated on behalf of the consumer and with the consumer's consent or with the consent of the consumer's legal representative by the discharge planner of the medical facility where the consumer resides at the time of application or the case manager. The discharge planner or case manager shall provide to the IME medical services unit all appropriate information needed regarding all the medically necessary service needs of the consumer. After completing the determination of ability to have all medically necessary service needs met within the scope of this waiver, the IME medical services unit shall inform the discharge planner or case manager on behalf of the consumer or the consumer's legal representative and send to the income

maintenance worker a copy of the decision as to whether all of the consumer's service needs can be met in a home- or community-based setting.

b. Eligibility for the HCBS BI waiver shall be effective as of the date when both the service eligibility and financial eligibility have been completed. Decisions shall be mailed or given to the consumer or the consumer's legal representative on the date when each eligibility determination is completed.

c. An applicant shall be given the choice between waiver services and institutional care. The applicant or legal representative shall complete and sign Form 470-4694, Case Management Comprehensive Assessment, indicating that the applicant has elected home- and community-based services. This shall be arranged by the medical facility discharge planner or case manager.

d. The medical facility discharge planner, if there is one involved, shall contact the appropriate case manager for the consumer's county of residence to initiate development of the consumer's service plan and initiation of waiver services.

e. HCBS BI waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

f. HCBS BI waiver services are not available in conjunction with other HCBS waiver programs or group foster care services.

g. The Medicaid case manager shall establish an HCBS BI waiver interdisciplinary team for each consumer and, with the team, identify the consumer's "need for service" based on the consumer's needs and desires as well as the availability and appropriateness of services.

83.83(3) *Effective date of eligibility.*

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A) and when the eligibility factors set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in rule 441—83.82(249A). Consumers who return to inpatient status in a medical institution for more than 30 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the brain injury waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.83(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12]

441—83.84(249A) Client participation. Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a predetermined participation amount to the cost of brain injury waiver services.

83.84(1) *Computation of client participation.* Client participation shall be computed by deducting an amount for the maintenance needs of the consumer which is 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

83.84(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific brain injury waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

441—83.85(249A) Redetermination. A complete financial redetermination of eligibility for brain injury waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.82(249A). A redetermination shall contain the components listed in rule 441—83.82(249A).

441—83.86(249A) Allowable services. Services allowable under the brain injury waiver are case management, respite, personal emergency response, supported community living, behavioral programming, family counseling and training, home and vehicle modification, specialized medical equipment, prevocational services, transportation, supported employment, adult day care, consumer-directed attendant care, interim medical monitoring and treatment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.43(249A).

441—83.87(249A) Service plan. A service plan shall be prepared and utilized for each HCBS BI waiver consumer. The service plan shall be developed by an interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager, providers, and others directly involved. The service plan shall be stored by the case manager for a minimum of three years. The service plan staffing shall be conducted before the current service plan expires.

83.87(1) *Information in plan.* The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

a. A listing of all services received by a consumer at the time of waiver program enrollment.

b. For supported community living:

(1) The consumer's living environment at the time of waiver enrollment.

(2) The number of hours per day of on-site staff supervision needed by the consumer.

(3) The number of other waiver consumers who will live with the consumer in the living unit.

c. An identification and justification of any restriction of a consumer's rights including, but not limited to:

(1) Maintenance of personal funds.

(2) Self-administration of medications.

d. The names of all providers responsible for providing all services.

e. All service funding sources.

f. The amount of the service to be received by the consumer.

g. Whether the consumer has elected the consumer choices option and, if so:

(1) The independent support broker selected by the consumer; and

(2) The financial management service selected by the consumer.

h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.87(2) *Use of nonwaiver services.* Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. Service plans for members aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager shall attach a written request for a variance from the limitation on supported community living to intermittent.

83.87(3) *Annual assessment.* The IME medical services unit shall assess the member annually and certify the member's need for long-term care services. The IME medical services unit shall be responsible for determining the level of care based on the completed Form 470-4694, Case Management Comprehensive Assessment, and supporting documentation as needed.

a. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

b. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

83.87(4) *Service file.* The Medicaid case manager must ensure that the consumer service file contains the consumer's service plan.

a. to *d.* Rescinded IAB 8/7/02, effective 10/1/02.

[**ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.88(249A) Adverse service actions.

83.88(1) *Denial.* An application for services shall be denied when it is determined by the department that:

a. The consumer is not eligible for the services because all of the medically necessary service needs cannot be met in a home- or community-based setting.

b. Service needs exceed the service unit or reimbursement maximums.

c. Service needs are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

e. The brain injury waiver service is not identified in the consumer's service plan.

f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.

g. The consumer receives services from other Medicaid waiver providers.

h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

83.88(2) *Reduction.* A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph *"a"* or *"b,"* apply.

83.88(3) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"d," "g,"* or *"h,"* apply.

b. Needed services are not available or received from qualifying providers.

c. The brain injury waiver service is not identified in the consumer's annual service plan.

d. Service needs are not met by the services provided.

e. Services needed exceed the service unit or reimbursement maximums.

f. Completion or receipt of required documents by the department or the medical facility discharge planner for the brain injury waiver service consumer has not occurred.

g. The consumer receives services from other Medicaid providers.

h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

441—83.89(249A) Appeal rights. Notice of adverse actions and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[**ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12]

441—83.90(249A) County reimbursement. Rescinded **ARC 0191C**, IAB 7/11/12, effective 7/1/12.

441—83.91(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.92 to **83.100** Reserved.

DIVISION VI—PHYSICAL DISABILITY WAIVER SERVICES

441—83.101(249A) Definitions.

"Adaptive" means age-appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

"Adult" means a person with a physical disability aged 18 years to 64 years.

"Appropriate" means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

"Assessment" means the review of the consumer's current functioning in regard to the consumer's situation, needs, strengths, abilities, desires and goals.

"Attorney in fact under a durable power of attorney for health care" means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"Behavior" means skills related to regulating one's own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

"Client participation" means the amount of the consumer's income that the person must contribute to the cost of physical disability waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

"Department" means the Iowa department of human services.

"Guardian" means a guardian appointed in probate court for an adult.

"Intermediate care facility for persons with an intellectual disability level of care" means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

"Managed care organization" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

"Medical institution" means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

"Nursing facility level of care" means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member's capacity to live independently.
2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

"Physical disability" means a severe, chronic condition that is attributable to a physical impairment that results in substantial limitations of physical functioning in three or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

"Service plan" means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process which addresses all relevant services and supports being provided. It may involve more than one provider.

"Skilled nursing facility level of care" means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

a. A physician order for all skilled services.

b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

c. An individualized care plan that identifies support needs.

d. Confirmation that skilled services are provided to the member.

e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

"Third-party payments" means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

"Waiver year" means a 12-month period commencing on April 1 of each year.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.102(249A) Eligibility. To be eligible for physical disability waiver services, a consumer must meet eligibility criteria set forth in subrule 83.102(1) and be determined to need a service allowable under the program per subrule 83.102(2).

83.102(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Have a physical disability.

b. Be blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act or the disability guidelines for the Medicaid employed people with disabilities coverage group.

c. Be ineligible for the HCBS intellectual disability waiver.

d. Have the ability to hire, supervise, and fire the provider as determined by the service worker, and be willing to do so, or have a parent or guardian named by probate court, or attorney in fact under a durable power of attorney for health care who will take this responsibility on behalf of the consumer.

e. Be eligible for Medicaid under 441—Chapter 75.

f. Be aged 18 years to 64 years.

g. Rescinded IAB 2/7/01, effective 2/1/01.

h. Be in need of skilled nursing or intermediate care facility level of care based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person's condition, and annually for reassessment of the person's level of care.

(2) Initial decisions on level of care shall be made for the department by the IME medical services unit within two working days of receipt of medical information. The IME medical services unit determines whether the level of care requirement is met based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

(3) Adverse decisions by the IME medical services unit may be appealed to the department pursuant to 441—Chapter 7.

i. Choose HCBS.

j. Use a minimum of one unit of service per calendar quarter under this program.

k. For the consumer choices option as set forth in 441—subrule 78.46(6), not be living in a residential care facility.

83.102(2) *Need for services.*

a. The applicant shall have a service plan which is developed by the applicant and a department service worker. The plan must be completed and approved before service provision.

(1) The service worker shall identify the need for service based on the needs of the applicant, as documented in Form 470-5044, Service Worker Comprehensive Assessment, as well as the availability and appropriateness of services.

(2) The service worker shall have a face-to-face visit with the member at least annually.

b. The total cost of physical disability waiver services, excluding the cost of home and vehicle modifications, shall not exceed $705.84 per month.

83.102(3) *Slots.* The total number of persons receiving HCBS physical disability waiver services in the state shall be limited to the number provided in the waiver approved by the Secretary of the U.S. Department of Health and Human Services. These slots shall be available on a first-come, first-served basis.

83.102(4) *County payment slots for persons requiring the ICF/MR level of care.* Rescinded IAB 10/6/99, effective 10/1/99.

83.102(5) *Securing a slot.*

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a slot is available for all new applicants for the HCBS physical disability waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no slot is available, the department shall enter applicants on the HCBS physical disabilities waiver waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added on the basis of the date the applicant requests HCBS physical disability program services. In the event that more than one application is received on the same day, applicants shall be entered on the waiting list on the basis of the day of the month of their birthday, the lowest number being first on the list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

83.102(6) *Securing a county payment slot.* Rescinded IAB 10/6/99, effective 10/1/99.

83.102(7) *HCBS physical disability waiver waiting list.* When services are denied because the limit on the number of slots is reached, a notice of decision denying service based on the limit and stating that the person's name shall be put on a waiting list shall be sent to the person by the department.

[**ARC 9650B**, IAB 8/10/11, effective 10/1/11; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1445C**, IAB 4/30/14, effective 7/1/14; **ARC 2848C**, IAB 12/7/16, effective 11/15/16]

441—83.103(249A) Application.

83.103(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed. Applications for this program may only be filed on or after April 1, 1999.

83.103(2) *Approval of application for eligibility.*

a. Applications for this waiver shall be initiated on behalf of the applicant who is a resident of a medical institution with the applicant's consent or with the consent of the applicant's legal representative by the discharge planner of the medical facility where the applicant resides at the time of application.

(1) The discharge planner shall have the applicant's primary care provider complete Form 470-4392, Level of Care Certification for HCBS Waiver Program, and submit it to the IME medical services unit.

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the discharge planner of the IME medical services unit's decision.

b. Applications for this waiver shall be initiated by the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on behalf of the applicant who is residing in the community.

(1) The applicant's primary care provider shall complete Form 470-4392, Level of Care Certification for HCBS Waiver Program, and submit it to the IME medical services unit.

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care.

c. Eligibility for this waiver shall be effective as of the date when both the eligibility criteria in subrule 83.102(1) and need for services in subrule 83.102(2) have been established. Decisions shall be mailed or given to the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on the date when each eligibility determination is completed.

d. An applicant shall be given the choice between waiver services and institutional care. The applicant or the applicant's parent, legal guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-5044, Service Worker Comprehensive Assessment, indicating that the applicant has elected home- and community-based services.

e. The applicant, the applicant's parent or guardian, or the applicant's attorney in fact under a durable power of attorney for health care shall cooperate with the service worker or case manager in the development of the service plan prior to the start of services.

f. HCBS physical disability waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

g. HCBS physical disability waiver services are not available in conjunction with other HCBS waiver programs. The consumer may also receive in-home health-related care service if eligible for that program.

83.103(3) *Effective date of eligibility.*

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in subrule 83.102(1).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in subrule 83.102(1) and when the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in subrule 83.102(1). Consumers who return to inpatient status in a medical institution for more than 30 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the physical disability waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.103(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the institutional level of care

requirement as determined by the IME medical services unit or an appeal decision shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for a prior institutionalization shall be applied to the waiver application.
[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.104(249A) Client participation. Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a client participation amount to the cost of physical disability waiver services.

83.104(1) *Computation of client participation.* Client participation shall be computed by deducting a maintenance needs allowance equal to 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

83.104(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific physical disability waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

441—83.105(249A) Redetermination. A complete financial redetermination of eligibility for the physical disability waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.102(249A). A redetermination shall contain the components listed in rule 441—83.102(249A).

441—83.106(249A) Allowable services. The services allowable under the physical disability waiver are consumer-directed attendant care, home and vehicle modification, personal emergency response system, transportation, specialized medical equipment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.46(249A).

441—83.107(249A) Individual service plan. An individualized service plan shall be prepared and used for each HCBS physical disability waiver consumer. The service plan shall be developed and approved by the consumer and the DHS service worker prior to services beginning and payment being made to the provider. The plan shall be reviewed by the consumer and the service worker annually, and the current version approved by the service worker.

83.107(1) *Information in plan.* The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

a. A listing of all services received by a consumer at the time of waiver program enrollment.

b. The name of all providers responsible for providing all services.

c. All service funding sources.

d. The amount of the service to be received by the consumer.

e. Whether the consumer has elected the consumer choices option and, if so:

(1) The independent support broker selected by the consumer; and

(2) The financial management service selected by the consumer.

f. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.107(2) *Annual assessment.* The IME medical services unit shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to paragraph 83.102(1)*"h"* and the appeal process at rule 441—83.109(249A), based on the completed Form 470-4392, Level of Care Certification for HCBS Waiver Program, and supporting documentation as needed.

a. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

b. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

83.107(3) *Case file.* Rescinded IAB 8/7/02, effective 10/1/02.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.108(249A) Adverse service actions.

83.108(1) *Denial.* An application for services shall be denied when it is determined by the department that:

a. All of the medically necessary service needs cannot be met in a home- or community-based setting.

b. Service needs exceed the reimbursement maximums.

c. Service needs are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

e. The physical disability waiver service is not identified in the consumer's service plan.

f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.

g. The consumer receives services from other Medicaid waiver providers.

h. The consumer or legal representative requests termination from the services.

83.108(2) *Reduction.* A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph *"a"* or *"b,"* apply.

83.108(3) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"d," "g,"* or *"h,"* apply.

b. Needed services are not available or received from qualifying providers.

c. The physical disability waiver service is not identified in the consumer's annual service plan.

d. Service needs are not met by the services provided.

e. Services needed exceed the service unit or reimbursement maximums.

f. Completion or receipt of required documents by the consumer for the physical disability waiver service has not occurred.

g. The consumer receives services from other Medicaid providers.

h. The consumer or legal representative requests termination from the services.

441—83.109(249A) Appeal rights. Notice of adverse actions and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

83.109(1) *Appeal to county.* Rescinded IAB 2/7/01, effective 2/1/01.

83.109(2) *Reconsideration request to IME medical services unit.* Rescinded IAB 9/5/12, effective 11/1/12.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12]

441—83.110(249A) County reimbursement. Rescinded IAB 10/6/99, effective 10/1/99.

441—83.111(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.112 to **83.120** Reserved.

DIVISION VII—HCBS CHILDREN'S MENTAL HEALTH WAIVER SERVICES

441—83.121(249A) Definitions.

"Assessment" means the review of the consumer's current functioning in regard to the consumer's situation, needs, abilities, desires, and goals.

"Case manager" means the person designated to provide Medicaid targeted case management services for the consumer.

"CMS" means the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

"Consumer" means an individual up to the age of 18 who is included in a Medicaid coverage group listed in 441—75.1(249A) and is a recipient of children's mental health waiver services.

"Deeming" means considering parental or spousal income or resources as income or resources of a consumer in determining eligibility for a consumer according to Supplemental Security Income program guidelines.

"Department" means the Iowa department of human services.

"Guardian" means a parent of a consumer or a legal guardian appointed by the court.

"HCBS" means home- and community-based services provided under a Medicaid waiver.

"IME" means the Iowa Medicaid enterprise.

"IME medical services unit" means the contracted entity in the Iowa Medicaid enterprise that determines level of care for consumers initially applying for or continuing to receive children's mental health waiver services.

"Interdisciplinary team" means the consumer, the consumer's family, and persons of varied professional and nonprofessional backgrounds with knowledge of the consumer's needs, as designated by the consumer and the consumer's family, who meet to develop a service plan based on the individualized needs of the consumer.

"ISIS" means the department's individualized services information system.

"Local office" means a department of human services office as described in 441—subrule 1.4(2).

"Managed care organization" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

"Medical institution" means a nursing facility, an intermediate care facility for persons with an intellectual disability, a psychiatric hospital or psychiatric medical institution for children, or a state mental health institute that has been approved as a Medicaid vendor.

"Mental health professional" means a person who meets all of the following conditions:

1. Holds at least a master's degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and
2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and
3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

"Psychiatric medical institution for children level of care" means that the member has been diagnosed with a serious emotional disturbance and an independent team as identified in 441—subrule 85.22(3) has certified that ambulatory care resources available in the community do not meet the treatment needs of the recipient, that proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician, and that the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

"Serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder that (1) is of sufficient duration to meet diagnostic criteria for the disorder specified by the current

version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association; and (2) has resulted in a functional impairment that substantially interferes with or limits a consumer's role or functioning in family, school, or community activities. "Serious emotional disturbance" shall not include neurodevelopmental disorders, substance-related disorders, or conditions or problems classified in the current version of the DSM as "other conditions that may be a focus of clinical attention," unless these conditions co-occur with another diagnosable serious emotional disturbance.

"Service plan" means a written, consumer-centered, outcome-based plan of services developed by the consumer's interdisciplinary team that addresses all relevant services and supports being provided. The service plan may involve more than one provider.

"Skill development" means that the service provided is habilitative and is intended to impart an ability or capacity to the consumer. Supervision without habilitation is not skill development.

"Targeted case management" means Medicaid case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90 for consumers eligible for the children's mental health waiver.

"Waiver year" for the children's mental health waiver means a 12-month period commencing on July 1 of each year.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.122(249A) Eligibility. To be eligible for children's mental health waiver services, a consumer must meet all of the following requirements:

83.122(1) *Age.* The consumer must be under 18 years of age.

83.122(2) *Diagnosis.* The consumer must be diagnosed with a serious emotional disturbance.

a. Initial certification. For initial application to the HCBS children's mental health waiver program, psychological documentation that substantiates a mental health diagnosis of serious emotional disturbance as determined by a mental health professional must be current within the 12-month period before the application date.

b. Ongoing certification. A mental health professional must complete an annual evaluation that substantiates a mental health diagnosis of serious emotional disturbance.

83.122(3) *Level of care.* The applicant must be certified as being in need of a level of care that, but for the waiver, would be provided in a psychiatric hospital serving children under the age of 21. The IME medical services unit or a managed care organization shall certify the applicant's level of care annually based on Form 470-4694, Case Management Comprehensive Assessment.

83.122(4) *Financial eligibility.* The consumer must be eligible for Medicaid as follows:

a. Be eligible for Medicaid under an SSI, SSI-related, FMAP, or FMAP-related coverage group; or

b. Be eligible under the special income level (300 percent) coverage group; or

c. Become eligible through application of the institutional deeming rules; or

d. Would be eligible for Medicaid if in a medical institution. For this purpose, deeming of parental or spousal income or resources ceases in the month after the month of application.

83.122(5) *Choice of program.* The applicant must choose HCBS children's mental health waiver services over institutional care, as indicated by the signature of the applicant's parent or legal guardian on Form 470-4694, Case Management Comprehensive Assessment.

83.122(6) *Need for service.* The consumer must have service needs that can be met under the children's mental health waiver program, as documented in the service plan developed in accordance with rule 441—83.12(249A).

a. The consumer must be a recipient of targeted case management services or be identified to receive targeted case management services immediately following program enrollment.

b. The total cost of children's mental health waiver services needed to meet the member's needs, excluding the cost of environmental modifications, adaptive devices and therapeutic resources, may not exceed $2,006.34 per month.

c. At a minimum, each consumer must receive one billable unit of a children's mental health waiver service per calendar quarter.

d. A consumer may not receive children's mental health waiver services and foster family care services under 441—Chapter 202 at the same time.

e. A consumer may be enrolled in only one HCBS waiver program at a time.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1445C**, IAB 4/30/14, effective 7/1/14; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16]

441—83.123(249A) Application. The Medicaid application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed for an application for HCBS children's mental health waiver services.

83.123(1) *Program limit.* The number of persons who may be approved for the HCBS children's mental health waiver shall be subject to the number of consumers to be served as set forth in the federally approved HCBS children's mental health waiver. When the number of applicants exceeds the number of consumers specified in the approved waiver, the consumer's application shall be rejected and the consumer's name shall be placed on a waiting list.

a. The local office shall determine if a payment slot is available by the end of the fifth working day after receipt of:

(1) A completed Form 470-2297, Health Services Application, from a consumer who is not currently a Medicaid member;

(2) Form 470-4694, Case Management Comprehensive Assessment, with HCBS waiver choice indicated by signature of a Medicaid member's parent or legal guardian; or

(3) A written request signed and dated by a Medicaid member's parent or legal guardian.

b. When a payment slot is available, the local office shall enter the application into ISIS to begin the waiver approval process.

(1) The department shall hold the payment slot for the consumer as long as reasonable efforts are being made to arrange services and the consumer has not been determined to be ineligible for the program.

(2) If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer must reapply for a new slot.

c. If no payment slot is available, the department shall enter the names of persons on a waiting list according to the following:

(1) The names of applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department;

(2) The names of Medicaid members shall be added to the waiting list on the date as specified in paragraph 83.123(1)*"a."*

(3) In the event that more than one application is received at one time, the names of consumers shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

d. Consumers whose names are on the waiting list shall be contacted to reapply as slots become available, based on the order of the waiting list, so that the number of approved consumers on the program is maintained.

(1) Once a payment slot is assigned, the department shall give written notice to the consumer within five working days.

(2) The department shall hold the payment slot for 30 days for the consumer to file a new application.

(3) If an application has not been filed within 30 days, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer originally assigned the slot must reapply for a new slot.

83.123(2) *Approval of waiver eligibility.*

a. Time limit. Applications for the HCBS children's mental health waiver program shall be processed within 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal Supplemental Security Income (SSI) benefits.

(2) The application is pending because the department has not received information for a reason that is beyond the control of the consumer or the department.

(3) The application is pending because the assessment has not been completed. When a determination is not completed 90 days after the date of application due to the lack of a completed assessment, the application shall be denied.

b. Notice of decisions. The department shall mail or give decisions to the applicant on the dates when eligibility and level of care determinations are completed.

83.123(3) *Effective date of eligibility.* The effective date of a consumer's eligibility for children's mental health waiver services shall be the first date that all of the following conditions exist:

a. All eligibility requirements are met; and

b. Eligibility and level of care determinations have been made.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.124(249A) Financial participation. A consumer must contribute to the cost of children's mental health waiver services to the extent of the consumer's total income less 300 percent of the maximum monthly payment for one person under the federal Supplemental Security Income (SSI) program.

441—83.125(249A) Redetermination. The department shall redetermine a consumer's eligibility for the children's mental health waiver at least once every 12 months or when there is significant change in the consumer's situation or condition.

83.125(1) *Eligibility review.*

a. Every 12 months, the department shall review a consumer's eligibility in accordance with procedures in rule 441—76.7(249A). The review shall verify continuing eligibility factors as specified in rule 441—83.122(249A).

b. The IME medical services unit or a managed care organization shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to rule 441—83.122(249A) and the appeal process at rule 441—83.129(249A), based on the completed department-approved assessment and supporting documentation as needed.

c. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

d. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

83.125(2) *Continuation of eligibility.* A consumer's waiver eligibility shall continue until one of the following conditions occurs.

a. The consumer fails to meet eligibility criteria listed in rule 441—83.122(249A).

b. The consumer is an inpatient of a medical institution for 30 or more consecutive days.

(1) After the consumer has spent 30 consecutive days in a medical institution, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

(2) If the consumer returns home after 30 consecutive days but no more than 60 days, the consumer must reapply for children's mental health waiver services, and the IME medical services unit must redetermine the consumer's level of care.

c. The consumer does not reside at the consumer's natural home for a period of 60 consecutive days. After the consumer has resided outside the home for 60 consecutive days, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

83.125(3) *Payment slot.* When a consumer loses waiver eligibility, the consumer's assigned payment slot shall revert for use to the next consumer on the waiting list.
[**ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.126(249A) Allowable services. Services allowable under the children's mental health waiver shall be provided as set forth in rule 441—78.52(249A) and shall include:

1. Environmental modifications, adaptive devices and therapeutic resources;
2. Family and community support services;
3. In-home family therapy; and
4. Respite care.

441—83.127(249A) Service plan. The consumer's case manager shall prepare an individualized service plan for each consumer that meets the requirements set for case plans in rule 441—130.7(234).

83.127(1) The service plan shall be developed through an interdisciplinary team process.

83.127(2) The service plan shall be developed annually or when there is significant change in the consumer's situation or condition.

83.127(3) The service plan shall be based on information in Form 470-4694, Case Management Comprehensive Assessment.

83.127(4) The service plan shall specify the type and frequency of the waiver services and the providers that will deliver the services.

83.127(5) The service plan shall identify and justify any restriction of the consumer's rights.
[**ARC 0306C**, IAB 9/5/12, effective 11/1/12]

441—83.128(249A) Adverse service actions.

83.128(1) *Denial.* An application for children's mental health waiver services shall be denied when the department determines that:

a. The consumer is not eligible for or in need of waiver services.

b. Needed services are not available or received from qualified providers.

c. Service needs exceed the limit on aggregate monthly costs established in 83.122(6)*"c"* or are not met by the services provided.

83.128(2) *Termination.* A consumer's participation in the children's mental health waiver program may be terminated when the department determines that:

a. The provisions of 441—paragraph 130.5(2)*"a," "b," "c," "g,"* or *"h"* apply.

b. The costs of the children's mental health waiver services for the consumer exceed the aggregate monthly costs established in 83.122(6)*"c."*

c. The consumer receives care in a hospital, nursing facility, psychiatric hospital serving children under the age of 21, or psychiatric medical institution for children for 30 days in any one stay.

d. The physical or mental condition of the consumer requires more care than can be provided in the consumer's own home, as determined by the consumer's case manager.

e. Service providers are not available.

83.128(3) *Reduction.* Reduction of services shall apply as specified in 441—paragraphs 130.5(3)*"a"* and *"b."*

441—83.129(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).
[**ARC 0306C**, IAB 9/5/12, effective 11/1/12]

These rules are intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

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CHAPTER 10
ENHANCED 911 TELEPHONE SYSTEMS

[Prior to 4/18/90, see Public Defense[601]Ch 10]
[Prior to 5/12/93, Disaster Services Division[607]Ch 10]

605—10.1(34A) Program description. The purpose of this program is to provide for the orderly development, installation, and operation of enhanced 911 emergency telephone systems and to provide a mechanism for the funding of these systems, either in whole or in part. These systems shall be operated under governmental management and control for the public benefit. These rules shall apply to each joint E911 service board or alternative 28E entity as provided in Iowa Code chapter 34A and to each provider of enhanced 911 service.

605—10.2(34A) Definitions. As used in this chapter, unless context otherwise requires:

"Access line" means an exchange access line that has the ability to access dial tone and reach a public safety answering point.

"Automatic location identification (ALI)" means a system capability that enables an automatic display of information defining a geographical location of the telephone used to place the 911 call.

"Automatic number identification (ANI)" means a capability that enables the automatic display of the number of the telephone used to place the 911 call.

"Call attendant" means the person who initially answers a 911 call.

"Call detail recording" means a means of establishing chronological and operational accountability for each 911 call processed, consisting minimally of the caller's telephone number, the date and time the 911 telephone equipment established initial connection (trunk seizure), the time the call was answered, the time the call was transferred (if applicable), the time the call was disconnected, the trunk line used, and the identity of the call attendant's position, also known as an ANI printout.

"Call relay method" means the 911 call is answered at the PSAP, where the pertinent information is gathered, and the call attendant relays the caller's information to the appropriate public or private safety agency for further action.

"Call transfer method" means the call attendant determines the appropriate responding agency and transfers the 911 caller to that agency.

"Central office (CO)" means a telephone company facility that houses the switching and trunking equipment serving telephones in a defined area.

"Coin-free access (CFA)" means coin-free dialing or no-coin dial tone which enables a caller to dial 911 or "0" for operator without depositing money or incurring a charge.

"Communications service" means a service capable of accessing, connecting with, or interfacing with a 911 system by dialing, initializing, or otherwise activating the system exclusively through the digits 911 by means of a local telephone device or wireless communications device.

"Communications service provider" means a service provider, public or private, that transports information electronically via landline, wireless, internet, cable, or satellite, including but not limited to wireless communications service providers, personal communications service, telematics and voice over internet protocol.

"Competitive local exchange service provider" means the same as defined in Iowa Code section 476.96.

"Conference transfer" means the capability of transferring a 911 call to the action agency and allowing the call attendant to monitor or participate in the call after it has been transferred to the action agency.

"Direct dispatch method" means 911 call answering and radio-dispatching functions, for a particular agency, are both performed at the PSAP.

"Director," unless otherwise noted, means the director of the homeland security and emergency management department.

"E911 communications council" means the council as established under the provisions of Iowa Code section 34A.15.

"E911 program manager" means that person appointed by the director of the homeland security and emergency management department, and working with the E911 communications council, to perform the duties specifically set forth in Iowa Code chapter 34A and this chapter.

"Emergency call" means a telephone request or text message request for service which requires immediate action to prevent loss of life, reduce bodily injury, prevent or reduce loss of property and respond to other emergency situations determined by local policy.

"Enhanced 911 (E911)" means the general term referring to emergency telephone systems with specific electronically controlled features, such as ALI, ANI, and selective routing.

"Enhanced 911 (E911) operating authority" means the public entity, which operates an E911 telephone system for the public benefit, within a defined enhanced 911 service area.

"Enhanced 911 (E911) service area" means the geographic area to be served, or currently served under an enhanced 911 service plan, provided that any enhanced 911 service area shall at a minimum encompass one entire county. The enhanced 911 service area may encompass more than one county and need not be restricted to county boundaries. This definition applies only to wire-line enhanced 911 service.

"Enhanced 911 (E911) service plan (wire-line)" means a plan, produced by a joint E911 service board, which includes the information required by Iowa Code subsection 34A.2(7).

"Enhanced 911 service surcharge" means a charge set by the joint E911 service board, approved by local referendum, and assessed on each access line which physically terminates within the E911 service area.

"Enhanced wireless 911 service area" means the geographic area to be served, or currently served, by a PSAP under an enhanced wireless 911 service plan.

"Enhanced wireless 911 service, phase I" means an emergency wireless telephone system with specific electronically controlled features such as ANI, specific indication of wireless communications tower site location, selective routing by geographic location of the tower site.

"Enhanced wireless 911 service, phase II" means an emergency wireless telephone system with specific electronically controlled features such as ANI and ALI and selective routing by geographic location of the 911 caller.

"Exchange" means a defined geographic area served by one or more central offices in which the telephone company furnishes services.

"Implementation" means the activity between formal approval of an E911 service plan and a given system design, and commencement of operations.

"Joint E911 service board" means those entities created under the provisions of Iowa Code section 34A.3, which include the legal entities created pursuant to Iowa Code chapter 28E referenced in Iowa Code subsection 34A.3(3).

"Local exchange carrier" means the same as defined in Iowa Code section 476.96.

"911 call" means any telephone call that is made by dialing the digits 911.

"911 system" means a telephone system that automatically connects a caller, dialing the digits 911, to a PSAP.

"Nonrecurring costs" means one-time charges incurred by a joint E911 service board or operating authority including, but not limited to, expenditures for E911 service plan preparation, capital outlay, communications equipment to receive and dispatch emergency calls, installation, and initial license to use subscriber names, addresses and telephone information.

"One-button transfer" means another term for a (fixed) transfer which allows the call attendant to transfer an incoming call by pressing a single button. For example, one button would transfer voice and data to a fire agency, and another button would be used for police, also known as "selective transfer."

"Political subdivision" means a geographic or territorial division of the state that would have the following characteristics: defined geographic area, responsibilities for certain functions of local government, public elections and public officers, and taxing power. Excluded from this definition are departments and divisions of state government and agencies of the federal government.

"Prepaid wireless telecommunications service" means a wireless communications service that provides the right to utilize mobile wireless service as well as other nontelecommunications services,

including the download of digital products delivered electronically, content and ancillary services, which must be paid for in advance, and that is sold in predetermined units or dollars of which the amount declines with use in a known amount.

"Provider" means a person, company or other business that provides, or offers to provide, 911 equipment, installation, maintenance, or access services.

"Public or private safety agency" means a unit of state or local government, a special purpose district, or a private firm, which provides or has the authority to provide firefighting, police, ambulance, emergency medical services or hazardous materials response.

"Public safety answering point (PSAP)" means a 24-hour, state, local, or contracted communications facility, which has been designated by the local service board to receive 911 service calls and dispatch emergency response services in accordance with the E911 service plan.

"Public switched telephone network" means a complex of diversified channels and equipment that automatically routes communications between the calling person and called person or data equipment.

"Recurring costs" means repetitive charges incurred by a joint E911 service board or operating authority including, but not limited to, personnel time directly associated with database management and personnel time directly associated with addressing, lease of access lines, lease of equipment, network access fees, communications equipment to receive and dispatch emergency calls, and applicable maintenance costs.

"Selective routing (SR)" means an enhanced 911 system feature that enables all 911 calls originating from within a defined geographical region to be answered at a predesignated PSAP.

"Subscriber" means any person, firm, association, corporation, agencies of federal, state and local government, or other legal entity responsible by law for payment for communication service from the telephone utility.

"Tariff" means a document filed by a telephone company with the state telephone utility regulatory commission which lists the communication services offered by the company and gives a schedule for rates and charges.

"Telecommunications device for the deaf (TDD)" means any type of instrument, such as a typewriter keyboard connected to the caller's telephone and involving special equipment at the PSAP which allows an emergency call to be made without speaking, also known as a TTY.

"Telematics" means a vehicle-based mobile data application which can automatically call for assistance if the vehicle is in an accident.

"Trunk" means a circuit used for connecting a subscriber to the public switched telephone network.

"Voice over internet protocol" means a technology used to transmit voice conversations over a data network such as a computer network or internet.

"Wireless communications service" means commercial mobile radio service. "Wireless communications service" includes any wireless two-way communications used in cellular telephone service, personal communications service, or the functional or competitive equivalent of a radio-telephone communications line used in cellular telephone service, a personal communications service, or a network access line. "Wireless communications service" does not include a service whose customers do not have access to 911 or 911-like service, a communications channel utilized only for data transmission, or a private telecommunications system.

"Wireless communications service provider" means a company that offers wireless communications service to users of wireless devices including but not limited to cellular, personal communications services, mobile satellite services, and enhanced specialized mobile radio.

"Wireless communications surcharge" means a surcharge of up to 65 cents imposed on each wireless communications service number provided in this state and collected as part of a wireless communications service provider's monthly billing to a subscriber.

"Wireless E911 phase 1" means a 911 call made from a wireless device in which the wireless service provider delivers the call-back number and the address of the tower that received the call to the appropriate public safety answering point.

"Wireless E911 phase 2" means a 911 call made from a wireless device in which the wireless service provider delivers the call-back number and the latitude and longitude coordinates of the wireless device to the appropriate public safety answering point.

"Wire-line E911 service surcharge" means a charge assessed on each wire-line access line which physically terminates within the E911 service area in accordance with Iowa Code section 34A.7.

[**ARC 8314B**, IAB 11/18/09, effective 12/23/09; **ARC 0602C**, IAB 2/20/13, effective 3/27/13; **ARC 1538C**, IAB 7/9/14, effective 8/13/14; **ARC 2270C**, IAB 11/25/15, effective 12/30/15; **ARC 2741C**, IAB 10/12/16, effective 9/14/16; **ARC 2835C**, IAB 12/7/16, effective 1/11/17]

605—10.3(34A) Joint E911 service boards. Each county board of supervisors shall establish a joint E911 service board.

10.3(1) *Membership.*

a. Each political subdivision of the state, having a public safety agency serving territory within the county E911 service area, is entitled to one voting membership. For the purposes of this paragraph, a township that operates a volunteer fire department providing fire protection services to the township, or a city that provides fire protection services through the operation of a volunteer fire department not financed through the operation of city government, shall be considered a political subdivision of the state having a public safety agency serving territory within the county.

b. Each private safety agency, such as privately owned ambulance services, airport security agencies, and private fire companies, serving territory within the county E911 service area, is entitled to a nonvoting membership on the board.

c. Public and private safety agencies headquartered outside but operating within a county E911 service area are entitled to membership according to their status as a public or private safety agency.

d. A political subdivision that does not operate its own public safety agency but contracts for the provision of public safety services is not entitled to membership on the joint E911 service board. However, its contractor is entitled to one voting membership according to the contractor's status as a public or private safety agency.

e. The joint E911 service board elects a chairperson and vice chairperson.

f. The joint E911 service board shall annually submit a listing of members, to include the political subdivision they represent and, if applicable, the associated 28E agreement, to the E911 program manager. A copy of the list shall be submitted within 30 days of adoption of the operating budget for the ensuing fiscal year and shall be on the prescribed form provided by the E911 program manager.

10.3(2) *Alternate 28E entity.* The joint E911 service board may organize as an Iowa Code chapter 28E agency as authorized in Iowa Code subsection 34A.3(3), provided that the 28E entity meets the voting and membership requirements of Iowa Code subsection 34A.3(1).

10.3(3) *Joint E911 service board bylaws.* Each joint E911 service board shall develop bylaws to specify, at a minimum, the following information:

a. The name of the joint E911 service board.

b. A list of voting and nonvoting members.

c. The date for the commencement of operations.

d. The mission.

e. The powers and duties.

f. The manner for financing activities and maintaining a budget.

g. The manner for acquiring, holding and disposing of property.

h. The manner for electing or appointing officers and terms of office.

i. The manner by which members may vote to include, if applicable, the manner by which votes may be weighted.

j. The manner for appointing, hiring, disciplining, and terminating employees.

k. The rules for conducting meetings.

l. The permissible method or methods to be employed in accomplishing the partial or complete termination of the board and the disposing of property upon such complete or partial termination.

m. Any other necessary and proper rules or procedures.

Each member shall sign the adopted bylaws.

The joint E911 service board shall record the signed bylaws with the county recorder and shall forward a copy of the signed bylaws to the E911 program manager at the homeland security and emergency management department.

10.3(4) *Executive board.* The joint E911 service board may, through its bylaws, establish an executive board to conduct the business of the joint E911 service board. Members of the executive board must be selected from the eligible voting members of the joint E911 service board. The executive board will have such other duties and responsibilities as assigned by the joint E911 service board.

10.3(5) *Meetings.*

a. The provisions of Iowa Code chapter 21, "Official Meetings Open to the Public," are applicable to joint E911 service boards.

b. Joint E911 service boards shall conduct meetings in accordance with their established bylaws and applicable state law.

[**ARC 7695B**, IAB 4/8/09, effective 5/13/09; **ARC 8314B**, IAB 11/18/09, effective 12/23/09; **ARC 1538C**, IAB 7/9/14, effective 8/13/14]

605—10.4(34A) Enhanced 911 service plan (wire-line).

10.4(1) The joint E911 service board shall be responsible for developing an E911 service plan as required by Iowa Code section 34A.3 and as set forth in these rules. The plan will remain the property of the joint E911 service board. Each joint E911 service board shall coordinate planning with each contiguous joint E911 service board. A copy of the plan and any modifications and addenda shall be submitted to:

a. The homeland security and emergency management department.

b. All public and private safety agencies serving the E911 service area.

c. All providers affected by the E911 service plan.

10.4(2) The E911 service plan shall, at a minimum, encompass the entire county, unless a waiver is granted by the director. Each plan shall include:

a. The mailing address of the joint E911 service board.

b. A list of voting members on the joint E911 service board.

c. A list of nonvoting members on the joint E911 service board.

d. The name of the chairperson and vice chairperson of the joint E911 service board.

e. A geographical description of the enhanced 911 service area.

f. A list of all public and private safety agencies within the E911 service area.

g. The number of public safety answering points within the E911 service area.

h. Identification of the agency responsible for management and supervision of the E911 emergency telephone communication system.

i. A statement of recurring and nonrecurring costs to be incurred by the joint E911 service board. These costs shall be limited to costs directly attributable to the provision of E911 service.

j. The total number of telephone access lines by telephone company or companies having points of presence within the E911 service area and the number of this total that is exempt from surcharge collection as provided in rule 605—10.9(34A) and Iowa Code subsection 34A.7(3).

k. If applicable, a schedule for implementation of the plan throughout the E911 service area. A joint E911 service board may decide not to implement E911 service.

l. The total property valuation in the E911 service area.

m. Maps of the E911 service area showing:

(1) The jurisdictional boundaries of all law enforcement agencies serving the area.

(2) The jurisdictional boundaries of all firefighting districts and companies serving the area.

(3) The jurisdictional boundaries of all ambulance and emergency medical service providers operating in the area.

(4) Telephone exchange boundaries and the location of telephone company central offices, including those located outside but serving the service area.

(5) The location of PSAP(s) within the service area.

n. A block drawing for each telephone central office within the service area showing the method by which the 911 call will be delivered to the PSAP(s).

o. A plan to migrate to an internet protocol-enabled next generation network.

10.4(3) All plan modifications and addenda shall be filed with, reviewed, and approved by the E911 program manager.

10.4(4) The E911 program manager shall base acceptance of the plan upon compliance with the provisions of Iowa Code chapter 34A and the rules herein.

10.4(5) The E911 program manager will notify in writing, within 20 days of review, the chairperson of the joint E911 service board of the approval or disapproval of the plan.

a. If the plan is disapproved, the joint E911 service board will have 90 days from receipt of notice to submit revisions/addenda.

b. Notice for disapproved plans will contain the reasons for disapproval.

c. The E911 program manager will notify the chairperson, in writing within 20 days of review, of the approval or disapproval of the revisions.

[**ARC 8314B**, IAB 11/18/09, effective 12/23/09; **ARC 0602C**, IAB 2/20/13, effective 3/27/13; **ARC 1538C**, IAB 7/9/14, effective 8/13/14]

605—10.5(34A) Wire-line E911 service surcharge.

10.5(1) One source of funding for the E911 emergency communications system shall come from a surcharge of one dollar per month, per access line on each access line subscriber.

10.5(2) The E911 program manager shall notify a local communications service provider scheduled to provide exchange access E911 service within an E911 service area that implementation of an E911 service plan has been approved by the joint E911 service board and by the E911 program manager and that collection of the surcharge is to begin within 60 days. The E911 program manager shall also provide notice to all affected public safety answering points. The 60-day notice to local exchange service providers shall also apply when an adjustment in the wire-line surcharge rate is made.

10.5(3) The local communications service provider shall collect the surcharge as a part of its monthly billing to its subscribers. The surcharge shall appear as a single line item on a subscriber's monthly billing entitled "E911 emergency communications service surcharge."

10.5(4) The local communications service provider may retain 1 percent of the surcharge collected as compensation for the billing and collection of the surcharge. If the compensation is insufficient to fully recover a provider's costs for the billing and collection of the surcharge, the deficiency shall be included in the provider's costs for rate-making purposes to the extent it is reasonable and just under Iowa Code section 476.6.

10.5(5) The local communications service provider shall remit the collected surcharge to the joint E911 service board on a calendar quarter basis within 20 days of the end of the quarter.

10.5(6) The joint E911 service board may request, not more than once each quarter, the following information from the local communications service provider:

a. The identity of the exchange from which the surcharge is collected.

b. The number of lines to which the surcharge was applied for the quarter.

c. The number of refusals to pay per exchange, if applicable.

d. The number of write-offs per exchange, if applicable.

e. The number of lines exempt per exchange.

f. The amount retained by the local communications service provider from the 1 percent administrative fee.

Access line counts and surcharge remittances are confidential public records as provided in Iowa Code section 34A.8.

10.5(7) Collection for a surcharge shall terminate if E911 service ceases to operate within the respective E911 service area. The E911 program manager for good cause may grant an extension.

a. The director shall provide 100 days' prior written notice to the joint E911 service board or the operating authority and to the local communications service provider(s) collecting the fee of the termination of surcharge collection.

b. Individual subscribers within the E911 service area may petition the joint E911 service board or the operating authority for a refund. Petitions shall be filed within one year of termination. Refunds may be prorated and shall be based on funds available and subscriber access lines billed.

c. At the end of one year from the date of termination, any funds not refunded and remaining in the E911 service fund and all interest accumulated shall be retained by the joint E911 service board. However, if the joint E911 service board ceases to operate any E911 service, the balance in the E911 service fund shall be payable to the homeland security and emergency management department. Moneys received by the department shall be used only to offset the costs for the administration of the E911 program.

[**ARC 0602C**, IAB 2/20/13, effective 3/27/13; **ARC 1538C**, IAB 7/9/14, effective 8/13/14]

605—10.6(34A) Waivers, variance request, and right to appeal.

10.6(1) All requests for variances or waivers shall be submitted to the E911 program manager in writing and shall contain the following information:

a. A description of the variance(s) or waiver(s) being requested.

b. Supporting information setting forth the reasons the variance or waiver is necessary.

c. A copy of the resolution or minutes of the joint E911 service board meeting which authorizes the application for a variance or waiver.

d. The signature of the chairperson of the joint E911 service board.

10.6(2) The E911 program manager may grant a variance or waiver based upon the provisions of Iowa Code chapter 34A or other applicable state law.

10.6(3) Upon receipt of a request for a variance or waiver, the E911 program manager shall evaluate the request and schedule a review within 20 working days of receipt of the request. Review shall be informal and the petitioner may present materials, documents and testimony in support of the petitioner's request. The E911 program manager shall determine if the request meets the criteria established and shall issue a decision within 20 working days. The E911 program manager shall notify the petitioner, in writing, of the acceptance or rejection of the petition. If the petition is rejected, such notice shall include the reasons for denial.

605—10.7(34A) Enhanced wireless E911 service plan. Each joint E911 service board, the department of public safety, the E911 communications council, and wireless service providers shall cooperate with the E911 program manager in preparing an enhanced wireless E911 service plan for statewide implementation of enhanced wireless E911 service.

10.7(1) *Plan specifications.* The enhanced wireless E911 service plan shall include, at a minimum, the following information:

1. Maps showing the geographic location within the county of each PSAP that receives enhanced wireless E911 telephone calls.
2. A list of all public safety answering points within the state of Iowa.
3. A set of guidelines for determining eligible cost as set forth in Iowa Code section 34A.7A.
4. A schedule for the implementation and maintenance of the next generation 911 systems to provide enhanced wireless 911 phase I and phase II service.

10.7(2) *Adoption by reference.* The "Wireless NG911 Implementation and Operations Plan," effective August 30, 2015, and available from the Homeland Security and Emergency Management Department, 7900 Hickman Road, Suite 500, Windsor Heights, Iowa, or at the Law Library in the Capitol Building, Des Moines, Iowa, is hereby adopted by reference effective December 30, 2015.

[**ARC 8314B**, IAB 11/18/09, effective 12/23/09; **ARC 0602C**, IAB 2/20/13, effective 3/27/13; **ARC 1538C**, IAB 7/9/14, effective 8/13/14; **ARC 2270C**, IAB 11/25/15, effective 12/30/15]

605—10.8(34A) Emergency communications service surcharge.

10.8(1) The E911 program manager shall adopt a monthly surcharge of one dollar to be imposed on each wireless communications service number provided in this state. The surcharge shall not be imposed on wire-line-based communications or prepaid wireless telecommunications service.

10.8(2) The E911 program manager shall order the imposition of a surcharge uniformly on a statewide basis and simultaneously on all communications service numbers by giving at least 60 days' prior notice to wireless carriers to impose a monthly surcharge as part of their periodic billings. The 60-day notice to wireless carriers shall also apply when making an adjustment in the wireless surcharge rate.

10.8(3) The wireless surcharge shall be one dollar per month, per customer service number, until changed by rule.

10.8(4) The communications service provider shall list the surcharge as a separate line item on the customer's billing indicating that the surcharge is for E911 emergency telephone service. The communications service provider is entitled to retain 1 percent of any wireless surcharge collected as a fee for collecting the surcharge as part of the subscriber's periodic billing. The wireless E911 surcharge is not subject to sales or use tax.

10.8(5) Surcharge funds shall be remitted on a calendar quarter basis by the close of business on the twentieth day following the end of the quarter with a remittance form as prescribed by the E911 program manager. Providers shall issue their checks or warrants to the Treasurer, State of Iowa, and remit to the E911 Program Manager, Homeland Security and Emergency Management Department, 7900 Hickman Road, Suite 500, Windsor Heights, Iowa 50324.

[**ARC 8314B**, IAB 11/18/09, effective 12/23/09; **ARC 0602C**, IAB 2/20/13, effective 3/27/13; **ARC 1538C**, IAB 7/9/14, effective 8/13/14; **ARC 2270C**, IAB 11/25/15, effective 12/30/15]

605—10.9(34A) E911 emergency communications fund.

10.9(1) Wireless E911 surcharge money, collected and remitted by wireless service providers, shall be placed in a fund within the state treasury under the control of the director.

10.9(2) Iowa Code section 8.33 shall not apply to moneys in the fund. Moneys earned as income, including as interest, from the fund shall remain in the fund until expended as provided in this subrule. However, moneys in the fund may be combined with other moneys in the state treasury for purposes of investment.

10.9(3) Moneys in the fund shall be expended and distributed in the following manner and order of priority:

a. An amount as appropriated by the general assembly to the department shall be allocated to the director and program manager for implementation, support, and maintenance of the functions of the director and program manager and to employ the auditor of state to perform an annual audit of the E911 emergency communications fund.

b. The program manager shall allocate to each joint E911 service board and to the department of public safety a minimum of $1,000 per calendar quarter for each public safety answering point (PSAP) within the service area of the department of public safety or joint E911 service board that has submitted an annual written request to the program manager. The written request shall be made with the Request for Wireless E911 Funds form contained in the Wireless NG911 Implementation and Operations Plan. The request is due to the program manager by May 15, or the next business day, of each year.

(1) The amount allocated under paragraph 10.9(3)*"b"* shall be 60 percent of the total amount of surcharge generated per calendar quarter. The minimum amount allocated to the department of public safety and the joint E911 board shall be $1,000 per PSAP operated by the respective authority.

(2) Additional funds shall be allocated as follows:

1. Sixty-five percent of the total dollars available for allocation shall be allocated in proportion to the square miles of the service area to the total square miles in this state.

2. Thirty-five percent of the total dollars available for allocation shall be allocated in proportion to the wireless E911 calls taken at the PSAP in the service area to the total number of wireless E911 calls originating in this state.

(3) The funds allocated in paragraph 10.9(3)*"b"* shall be used by the PSAPs for costs related to the receipt and disposition of 911 calls.

c. The program manager shall allocate 10 percent of the total amount of surcharge generated per calendar quarter to wireless carriers to recover their costs to deliver wireless E911 phase I services

as defined in the Federal Communications Commission (FCC) Docket 94-102 and further defined in the FCC's letter to King County, Washington, dated May 7, 2001. If this allocation is insufficient to reimburse all wireless carriers for the wireless service provider's eligible expenses, the program manager shall allocate a prorated amount to each wireless carrier equal to the percentage of the provider's eligible expenses as compared to the total eligible expenses for all wireless carriers for the calendar quarter during which expenses were submitted. When prorated expenses are paid, the remaining unpaid expenses shall no longer be eligible for payment under paragraph 10.9(3)*"c."* This allocation is for the period beginning July 1, 2013, and ending June 30, 2026.

d. The program manager shall reimburse communications service providers on a calendar quarter basis for carriers' eligible expenses for transport costs between the wireless selective router and the PSAPs related to the delivery of wireless E911 phase I services and the integration of an Internet protocol-enabled next generation 911 network as specified in the Wireless NG911 Implementation and Operations Plan.

e. The program manager shall reimburse wire-line carriers and third-party E911 automatic location information database providers on a quarterly basis for the costs of maintaining and upgrading the E911 components and functionalities beyond the input to the E911 selective router, including the E911 selective router and the automatic location information database.

f. The program manager shall allocate $4,380,000 to the department of public safety in the fiscal year beginning July 1, 2016, and ending June 30, 2017, for payments and other costs due under the financing agreement entered into by the treasurer of state for building the statewide interoperable communications system pursuant to Iowa Code section 29C.23(2) as amended by 2016 Iowa Acts, Senate File 2326.

g. The department may, in a reserve account established within the E911 emergency communications fund, credit each fiscal year an amount of up to 12½ percent of the annual emergency communications service surcharge collected pursuant to rule 605—10.8(34A) and the prepaid wireless E911 surcharge collected pursuant to rule 605—10.17(34A). However, the moneys contained in such reserve account shall not exceed 12½ percent of the total surcharges collected for each fiscal year. Moneys credited to the reserve account shall only be used by the department for the purpose of repairing or replacing equipment in the event of a catastrophic equipment failure, as determined by the director.

h. If moneys remain in the fund after all obligations are fully paid under paragraphs 10.9(3)*"a," "b," "c," "d," "e," "f,"* and *"g,"* an amount of up to $4,400,000 shall, for the fiscal year beginning July 1, 2016, and ending June 30, 2017, be expended and distributed in the following priority order:

(1) The director, in consultation with the program manager and the E911 communications council, may provide grants for nonrecurring costs to the department of public safety or joint E911 service board operating a PSAP agreeing to consolidate. For purposes of this subparagraph, "consolidate" means either the consolidation of all PSAP systems, functions, enhanced 911 service areas, and physical facilities of two or more PSAPs, resulting in responsibility by the consolidated PSAP for all call answering and dispatch functions for the combined enhanced 911 service area, or the consolidation of two or more PSAPs utilizing shared services technology to combine PSAP systems, including but not limited to 911 call processing equipment, computer-aided dispatch, mapping, radio, and logging recorders. Such a grant to a PSAP shall not exceed one-half of the projected cost of consolidation, or $200,000, whichever is less. The department of public safety or joint E911 service board wishing to apply for such funds shall complete an Intent to Consolidate Application form prior to December 1, 2016. The form can be found on the department's Web site, www.homelandsecurity.iowa.gov. Such applications shall provide a detailed consolidation plan and demonstrate that the proposed project shall be completed prior to June 30, 2017.

(2) The program manager, in consultation with the E911 communications council, shall allocate an amount, not to exceed $100,000 per fiscal year, for development of public awareness and educational programs related to the use of 911 by the public; for educational programs for personnel responsible for the maintenance, operation, and upgrading of local E911 systems; and for the expenses of members of the E911 communications council for travel, monthly meetings, and training, provided, however, that the members have not received reimbursement funds for such expenses from another source.

(3) The program manager shall allocate an equal amount of moneys to each PSAP for the following costs:

1. Costs related to the receipt and disposition of 911 calls, including hardware and software for an Internet protocol-enabled next generation 911 network as specified in the Wireless NG911 Implementation and Operations Plan.

2. Local costs related to access the statewide interoperable communications system pursuant to Iowa Code section 29C.23 as amended by 2016 Iowa Acts, Senate File 2326.

(4) Any moneys remaining in the fund at the end of each fiscal year shall not revert to the general fund of the state but shall remain available for the purposes of the fund.

10.9(4) Payments to local communications service providers and wireless service providers shall be made quarterly, based on original, itemized claims or invoices presented within 20 days of the end of the calendar quarter. Claims or invoices not submitted within 20 days of the end of the calendar quarter are not eligible for reimbursement and may not be included in future claims and invoices. Payments to providers shall be made in accordance with these rules and the State Accounting Policy and Procedures Manual.

10.9(5) Local communications service providers shall be reimbursed for only those items and services that are defined as eligible in the enhanced wireless 911 service plan and when initiation of service has been ordered and authorized by the E911 program manager.

10.9(6) If it is found that an overpayment has been made to an entity, the E911 program manager shall attempt recovery of the debt from the entity by certified letter. Due diligence shall be documented and retained at the homeland security and emergency management department. If resolution of the debt does not occur and the debt is at least $50, the homeland security and emergency management department will then utilize the income offset program through the department of revenue. Until resolution of the debt has occurred, the homeland security and emergency management department may withhold future payments to the entity.

[**ARC 0602C**, IAB 2/20/13, effective 3/27/13; **ARC 1538C**, IAB 7/9/14, effective 8/13/14; **ARC 2270C**, IAB 11/25/15, effective 12/30/15; **ARC 2741C**, IAB 10/12/16, effective 9/14/16; **ARC 2835C**, IAB 12/7/16, effective 1/11/17]

605—10.10(34A) E911 surcharge exemptions. The following agencies, individuals, and organizations are exempt from imposition of the E911 surcharge:

1. Federal agencies and tax-exempt instrumentalities of the federal government.

2. Indian tribes for access lines on the tribe's reservation upon filing a statement with the joint E911 service board, signed by appropriate authority, requesting surcharge exemption.

3. An enrolled member of an Indian tribe for access lines on the reservation, who does not receive E911 service, and who annually files a signed statement with the joint E911 service board that the person is an enrolled member of an Indian tribe living on a reservation and does not receive E911 service. However, once E911 service is provided, the member is no longer exempt.

4. Official station testing lines owned by the provider.

5. Individual wire-line subscribers to the extent that they shall not be required to pay on a single periodic billing the surcharge on more than 100 access lines, or their equivalent, in an E911 service area.

All other subscribers not listed above, that have or will have the ability to access 911, are required to pay the surcharge, if imposed by the official order of the E911 program manager.

605—10.11(34A) E911 service fund.

10.11(1) The department of public safety and each joint E911 service board have the responsibility for the E911 service fund.

a. An E911 service fund shall be established in the office of the county treasurer for each joint E911 service board and with the state treasurer for the department of public safety.

b. Collected surcharge moneys and any interest thereon, as authorized in Iowa Code chapter 34A, shall be deposited into the E911 service fund. E911 surcharge moneys must be kept separate from all other sources of revenue utilized for E911 systems.

c. For joint E911 service boards, withdrawal of moneys from the E911 service fund shall be made on warrants drawn by the county auditor, per Iowa Code section 331.506, supported by claims

and vouchers approved by the chairperson or vice chairperson of the joint E911 service board or the appropriate operating authority so designated in writing.

d. For the department of public safety, withdrawal of moneys from the E911 service fund shall be made in accordance with state laws and administrative rules.

10.11(2) The E911 service funds shall be subject to examination by the department at any time during usual business hours. E911 service funds are subject to the audit provisions of Iowa Code chapter 11. A copy of all audits of the E911 service fund shall be furnished to the department within 30 days of receipt. If through the audit or monitoring process the department determines that a joint E911 service board is not adhering to an approved plan or does not have a valid board membership, or if the department determines that a joint E911 service board or the department of public safety is not using funds in the manner prescribed in these rules or Iowa Code chapter 34A, the director may, after notice and hearing, suspend surcharge imposition and order termination of expenditures from the E911 service fund. The joint E911 service board or department of public safety is not eligible to receive or expend surcharge moneys until such time as the E911 program manager determines that the board or department of public safety is in compliance with the approved plan, board membership, and fund usage limitations.
[**ARC 8314B**, IAB 11/18/09, effective 12/23/09; **ARC 1538C**, IAB 7/9/14, effective 8/13/14]

605—10.12(34A) Operating budgets. By March 31 of each year, each joint E911 service board and the department of public safety shall provide to the E911 program manager a copy of the operating budget for the ensuing fiscal year for the fund as established under subrule 10.11(1).
[**ARC 1538C**, IAB 7/9/14, effective 8/13/14]

605—10.13(34A) Limitations on use of funds. Surcharge moneys in the E911 service fund may be used to pay recurring and nonrecurring costs including, but not limited to, network equipment, software, database, addressing, initial training, and other start-up, capital, and ongoing expenditures. E911 surcharge moneys shall be used only to pay costs directly attributable to the provision of E911 telephone systems and services and may include costs directly attributable to the receipt and disposition of the 911 call.
[**ARC 0602C**, IAB 2/20/13, effective 3/27/13]

605—10.14(34A) Minimum operational and technical standards.

10.14(1) Each E911 system, supplemented with E911 surcharge moneys, shall, at a minimum, employ the following features:

a. ALI (automatic location identification).

b. ANI (automatic number identification).

c. Ability to selectively route.

d. Each PSAP shall provide two emergency seven-digit numbers arranged in rollover configuration for use by telephone company operators for transferring a calling party to the PSAP over the wire-line network. Wireless calls must be transferred to PSAPs that are capable of accepting ANI and ALI.

e. ANI and ALI information shall be maintained and updated in such a manner as to allow for 95 percent or greater degree of accuracy.

10.14(2) E911 public safety answering points shall adhere to the following minimum standards:

a. The PSAP shall operate 7 days per week, 24 hours per day, with operators on duty at all times.

b. The primary published emergency number in the E911 service area shall be 911.

c. All PSAPs will maintain interagency communications capabilities for emergency coordination purposes, to include radio as well as land line direct or dial line.

d. Each PSAP shall develop and maintain a PSAP standard operating procedure for receiving and dispatching emergency calls.

e. The date and time of each 911 emergency call shall be documented using an automated call detail recording device or other communications center log. Such logs shall be maintained for a period of not less than one year.

f. If a call transfer method of handling 911 calls is employed, a 99 percent degree of reliability of transferred calls from a PSAP to responding agencies shall be maintained. All transferred calls shall employ, to the closest extent possible, conference transfer capabilities which provide that the call be announced and monitored by the PSAP operator to ensure that the call has been properly transferred.

g. PSAPs not employing the transfer method of handling 911 emergency calls shall use the call relay method. Information shall be exchanged between the PSAP receiving the call and an appropriate emergency response agency or dispatch center having jurisdiction in the area of the emergency. In no case during an emergency 911 call shall the caller be referred to another telephone number and required to hang up and redial. The call relay method shall also prevail in circumstances where emergency calls enter the 911 system (whether by design or by happenstance) from outside the E911 service area.

h. Access control and security of PSAPs and associated dispatch centers shall be designed to prevent disruption of operations and provide a safe and secure environment of communication operations.

i. PSAP supervision shall ensure that all telephone company employees, whose normal activities may involve contact with facilities associated with the 911 service, are familiar with safeguarding of facilities' procedures.

j. Emergency electrical power shall be provided for the PSAP environment that will ensure continuous operations and communications during a power outage. Such power should start automatically in the event of power failure and shall have the ability to be sustained for a minimum of 48 hours.

k. The PSAP shall make every attempt to disallow the intrusion by automatic dialers, alarm systems, or automatic dialing and announcing devices on a 911 trunk. If intrusion by one of these devices should occur, those responsible for PSAP operations shall make every attempt to contact the responsible party to ensure there is no such further occurrence by notifying the party that knowing and intentional interference with emergency telephone calls constitutes a crime under Iowa Code section 727.5. Those responsible for PSAP operations shall report persons who repeatedly use automatic dialers, alarm systems, or automatic announcing devices on 911 trunk lines to the county attorney for investigation of possible violations of section 727.5.

l. Each PSAP shall be equipped with an appropriate telecommunications device for the deaf (TDD) in accordance with 28 CFR Part 35.162, July 26, 1991.

10.14(3) Communications service providers shall adhere to the following minimum requirements:

a. The PSAP and E911 program manager shall be notified of all service interruptions in accordance with 47 CFR Part 4.

b. All communications service providers shall submit separate itemized bills to the E911 program manager, the department of public safety, a joint E911 service board or PSAP operating authority, as appropriate.

c. The communications service provider shall respond, within a reasonable length of time, to all appropriate requests for information from the director, the department of public safety, a joint E911 service board or operating authority and shall expressly comply with the provisions of Iowa Code section 34A.8.

d. Access to the wireless E911 selective router shall be approved by the E911 program manager. Communications service providers must provide the company name, address and point of contact with their request. If the communications service provider utilizes a third-party vendor, the vendor must provide this information listing the vendor's customer's requested information.

10.14(4) Voluntary standards. Current technical and operational standards applying to E911 systems and services can be found in the "American Society for Testing and Materials Standard Guide for Planning and Developing 911 Enhanced Telephone Systems" and in publications issued by the National Emergency Number Association. Master street address guides are encouraged to be developed and maintained by using National Emergency Number Association technical standards 02-010 and 02-011. Standards contained in these documents shall be considered as guidance, and adherence thereto shall be voluntary. Notwithstanding the minimum standards published in these rules, it is intended that E911 communications service providers and joint E911 service boards and operating authorities

employ the best and most affordable technologies and methods available in providing E911 services to the public.
[**ARC 0602C**, IAB 2/20/13, effective 3/27/13; **ARC 1538C**, IAB 7/9/14, effective 8/13/14]

605—10.15(34A) Administrative hearings and appeals.

10.15(1) E911 program manager decisions regarding the acceptance or refusal of an E911 service plan, in whole or in part, the implementation of E911 and the imposition of the E911 surcharge within a specific E911 service area may be contested by an affected party.

10.15(2) Request for hearing shall be made in writing to the homeland security and emergency management department director within 30 days of the E911 program manager's mailing or serving a decision and shall state the reason(s) for the request and shall be signed by the appropriate authority.

10.15(3) The director shall schedule a hearing within 10 working days of receipt of the request for hearing. The director shall preside over the hearing, at which time the appellant may present any evidence, documentation, or other information regarding the matter in dispute.

10.15(4) The director shall issue a ruling regarding the matter within 20 working days of the hearing.

10.15(5) Any party adversely affected by the director's ruling may file a written request for a rehearing within 20 days of issuance of the ruling. A rehearing will be conducted only when additional evidence is available, the evidence is material to the case, and good cause existed for the failure to present the evidence at the initial hearing. The director will schedule a hearing within 20 days after the receipt of the written request. The director shall issue a ruling regarding the matter within 20 working days of the hearing.

10.15(6) Any party adversely affected by the director's ruling may file a written appeal to the director of the homeland security and emergency management department. The appeal request shall contain information identifying the appealing party, the ruling being appealed, specific findings or conclusions to which exception is taken, the relief sought, and the grounds for relief. The director shall issue a ruling regarding the matter within 90 days of the hearing. The director's ruling constitutes final agency action for purposes of judicial review.
[**ARC 7695B**, IAB 4/8/09, effective 5/13/09; **ARC 0602C**, IAB 2/20/13, effective 3/27/13; **ARC 1538C**, IAB 7/9/14, effective 8/13/14]

605—10.16(34A) Confidentiality. All financial or operations information provided by a communications service provider to the E911 program manager shall be identified by the provider as confidential trade secrets under Iowa Code section 22.7(3) and shall be kept confidential as provided under Iowa Code section 22.7(3) and Iowa Administrative Code 605—Chapter 5. Such information shall include numbers of accounts, numbers of customers, revenues, expenses, and the amounts collected from said communications service provider for deposit in the fund. Notwithstanding such requirements, aggregate amounts and information may be included in reports issued by the director if the aggregated information does not reveal any information attributable to an individual communications service provider.
[**ARC 0602C**, IAB 2/20/13, effective 3/27/13; **ARC 1538C**, IAB 7/9/14, effective 8/13/14]

605—10.17(34A) Prepaid wireless E911 surcharge. Administration of the prepaid wireless E911 surcharge is under the control of the Iowa department of revenue. To administer this function, the department has adopted rules that can be found in 701—paragraph 224.6(2)*"b"* and rule 701—224.8(34A), Iowa Administrative Code.
[**ARC 0602C**, IAB 2/20/13, effective 3/27/13]

These rules are intended to implement Iowa Code chapter 34A.

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PUBLIC HEALTH DEPARTMENT[641]

Rules of divisions under this department "umbrella" include Professional Licensure[645], Dental Board[650], Medical Board[653], Nursing Board[655] and Pharmacy Board[657]

CHAPTER 1
REPORTABLE DISEASES, POISONINGS AND CONDITIONS, AND QUARANTINE AND ISOLATION

CHAPTER 2
HEPATITIS PROGRAMS

CHAPTER 3
EARLY HEARING DETECTION AND INTERVENTION (EHDI) PROGRAM

EARLY HEARING DETECTION AND INTERVENTION (EHDI) PROGRAM

HEARING AIDS AND AUDIOLOGIC SERVICES FUNDING PROGRAM

CHAPTER 4
CENTER FOR CONGENITAL AND INHERITED DISORDERS

CENTER FOR CONGENITAL AND INHERITED DISORDERS ADVISORY COMMITTEE (CIDAC)

CHAPTER 5
MATERNAL DEATHS

CHAPTER 6
Reserved

CHAPTER 7
IMMUNIZATION AND IMMUNIZATION EDUCATION: PERSONS ATTENDING ELEMENTARY OR SECONDARY SCHOOLS, LICENSED CHILD CARE CENTERS OR INSTITUTIONS OF HIGHER EDUCATION

CHAPTER 8
IOWA CARE FOR YOURSELF (IA CFY) PROGRAM

CHAPTER 9
OUTPATIENT DIABETES EDUCATION PROGRAMS

CHAPTER 14
WATER TREATMENT SYSTEMS

CHAPTER 15
SWIMMING POOLS AND SPAS

SWIMMING POOLS

ADMINISTRATION

SPAS

CHAPTERS 16 to 19
Reserved

CHAPTER 20
COMMUNITY WATER FLUORIDATION GRANT PROGRAM

CHAPTER 21
CENTRAL REGISTRY FOR
BRAIN AND SPINAL CORD INJURIES

CHAPTER 22
PRACTICE OF TATTOOING

CHAPTER 23
PLUMBING AND MECHANICAL SYSTEMS BOARD—LICENSEE PRACTICE

CHAPTER 24
PRIVATE WELL TESTING, RECONSTRUCTION, AND
PLUGGING—GRANTS TO COUNTIES

CHAPTER 30
CONTINUING EDUCATION FOR PLUMBING AND MECHANICAL SYSTEMS PROFESSIONALS

CHAPTER 31
PLUMBING AND MECHANICAL SYSTEMS BOARD—WAIVERS OR VARIANCES FROM ADMINISTRATIVE RULES

CHAPTER 32
PLUMBING AND MECHANICAL SYSTEMS BOARD—LICENSEE DISCIPLINE

CHAPTER 33
PLUMBING AND MECHANICAL SYSTEMS BOARD—CONTESTED CASES

CHAPTER 37
PHYSICAL PROTECTION OF CATEGORY 1 AND CATEGORY 2 QUANTITIES OF RADIOACTIVE MATERIAL

GENERAL PROVISIONS

BACKGROUND INVESTIGATIONS AND ACCESS CONTROL PROGRAM

PHYSICAL PROTECTION REQUIREMENTS DURING USE

CHAPTER 40
STANDARDS FOR PROTECTION AGAINST RADIATION

STORAGE AND CONTROL OF LICENSED OR REGISTERED SOURCES OF RADIATION

40.54	Reserved
40.55(136C)	Security and control of licensed or registered sources of radiation
40.56(136C)	Control of sources of radiation not in storage
40.57 to 40.59	Reserved

PRECAUTIONARY PROCEDURES

40.60(136C)	Caution signs
40.61(136C)	Posting requirements
40.62(136C)	Exceptions to posting requirements
40.63(136C)	Labeling containers and radiation machines
40.64(136C)	Exemptions to labeling requirements
40.65(136C)	Procedures for receiving and opening packages
40.66 to 40.69	Reserved

WASTE DISPOSAL

40.70(136C)	General requirements
40.71(136C)	Method for obtaining approval of proposed disposal procedures
40.72(136C)	Disposal by release into sanitary sewerage
40.73(136C)	Treatment or disposal by incineration
40.74(136C)	Disposal of specific wastes
40.75(136C)	Transfer for disposal and manifests
40.76(136C)	Compliance with environmental and health protection regulations
40.77(136C)	Disposal of certain by-product material
40.78 and 40.79	Reserved

RECORDS

40.80(136C)	General provisions
40.81(136C)	Records of radiation protection programs
40.82(136C)	Records of surveys
40.83(136C)	Records of tests for leakage or contamination of sealed sources
40.84(136C)	Records of prior occupational dose
40.85(136C)	Records of planned special exposures
40.86(136C)	Records of individual monitoring results
40.87(136C)	Records of dose to individual members of the public
40.88(136C)	Records of waste disposal
40.89(136C)	Records of testing entry control devices for very high radiation areas
40.90(136C)	Form of records
40.91 to 40.94	Reserved

REPORTS

40.95(136C)	Reports of stolen, lost, or missing licensed or registered sources of radiation
40.96(136C)	Notification of incidents
40.97(136C)	Reports of exposures, radiation levels, and concentrations of radioactive material exceeding the constraints or limits
40.98(136C)	Reports of planned special exposures
40.99(136C)	Reports of transactions involving nationally tracked sources
40.100(136C)	Reports of individual monitoring
40.101(136C)	Notifications and reports to individuals
40.102(136C)	Reports of leaking or contaminated sealed sources
40.103 and 40.104	Reserved

CHAPTERS 53 and 54
Reserved

CHAPTER 55
ADVISORY COUNCIL ON BRAIN INJURIES

CHAPTER 56
BRAIN INJURY SERVICES PROGRAM

CHAPTER 57
PLUMBING AND MECHANICAL SYSTEMS BOARD—
DECLARATORY ORDERS

CHAPTER 58
PLUMBING AND MECHANICAL SYSTEMS BOARD—
AGENCY PROCEDURE FOR RULE MAKING

CHAPTER 59
PLUMBING AND MECHANICAL SYSTEMS BOARD—FAIR INFORMATION
PRACTICES AND PUBLIC RECORDS

CHAPTER 60
PLUMBING AND MECHANICAL SYSTEMS BOARD—
NONCOMPLIANCE REGARDING CHILD SUPPORT, NONPAYMENT OF STATE DEBT,
AND NONCOMPLIANCE REGARDING STUDENT LOAN REPAYMENT

CHAPTER 61
STATE MECHANICAL CODE

CHAPTER 62
PLUMBING AND MECHANICAL SYSTEMS BOARD—
MILITARY SERVICE AND VETERAN RECIPROCITY

CHAPTERS 63 to 66
Reserved

CHAPTER 67
BLOOD LEAD TESTING

CHAPTER 68
CONTROL OF LEAD-BASED PAINT HAZARDS

CHAPTER 69
RENOVATION, REMODELING, AND REPAINTING—
LEAD HAZARD NOTIFICATION PROCESS

CHAPTER 96
BIRTH REGISTRATION

CHAPTER 97
DEATH REGISTRATION AND DISPOSITION OF DEAD HUMAN BODIES

CHAPTER 98
MARRIAGE REGISTRATION

CHAPTER 99
VITAL RECORDS MODIFICATIONS

CHAPTER 100
VITAL RECORDS REGISTRIES AND REPORTS

CHAPTERS 101 to 106
Reserved

CHAPTER 107
BOARD-CERTIFIED BEHAVIOR ANALYST AND BOARD-CERTIFIED ASSISTANT BEHAVIOR ANALYST (BCBA/BCaBA) GRANTS PROGRAM

CHAPTER 136
TRAUMA REGISTRY

CHAPTER 137
TRAUMA EDUCATION AND TRAINING

CHAPTER 138
TRAUMA SYSTEM ADVISORY COUNCIL

CHAPTER 139
IOWA LAW ENFORCEMENT EMERGENCY CARE PROVIDER

CHAPTER 140
EMERGENCY MEDICAL SERVICES SYSTEM DEVELOPMENT GRANTS FUND

CHAPTER 141
LOVE OUR KIDS GRANT

CHAPTER 142
OUT-OF-HOSPITAL DO-NOT-RESUSCITATE ORDERS

CHAPTER 143
AUTOMATED EXTERNAL DEFIBRILLATOR PROGRAM

AUTOMATED EXTERNAL DEFIBRILLATOR GRANT PROGRAM

AUTOMATED EXTERNAL DEFIBRILLATOR MAINTENANCE

FIRE DEPARTMENT RESPONSE WITH AUTOMATED EXTERNAL DEFIBRILLATOR

CHAPTER 144
EMERGENCY MEDICAL SERVICES—AIR MEDICAL SERVICE PROGRAM AUTHORIZATION

CHAPTER 145
IOWA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT

CHAPTERS 146 to 149
Reserved

CHAPTER 150
IOWA REGIONALIZED SYSTEM OF PERINATAL HEALTH CARE

CHAPTER 151
TOBACCO USE PREVENTION AND CONTROL
COMMUNITY PARTNERSHIP INITIATIVE

CHAPTER 152
TOBACCO USE PREVENTION AND CONTROL FUNDING PROCESS

CHAPTER 153
SMOKEFREE AIR

CHAPTER 154
MEDICAL CANNABIDIOL ACT REGISTRATION CARD PROGRAM

CHAPTER 155
LICENSURE STANDARDS FOR SUBSTANCE USE DISORDER AND PROBLEM GAMBLING TREATMENT PROGRAMS

CHAPTER 156
LICENSURE STANDARDS FOR SUBSTANCE ABUSE TREATMENT PROGRAMS IN CORRECTIONAL FACILITIES

CHAPTER 157
STANDARDS FOR SUBSTANCE ABUSE TREATMENT AND ASSESSMENT PROGRAMS AND THE OPERATING A MOTOR VEHICLE WHILE INTOXICATED (OWI) LAW

CHAPTER 158
REGIONS FOR SUBSTANCE ABUSE PREVENTION AND TREATMENT

CHAPTERS 159 to 169
Reserved

CHAPTER 170
ORGANIZATION OF THE DEPARTMENT

CHAPTER 171
PETITIONS FOR RULE MAKING

CHAPTER 172
DECLARATORY ORDERS

CHAPTER 173
CONTESTED CASES

CHAPTER 174
AGENCY PROCEDURE FOR RULE MAKING
(Uniform Rules)

CHAPTER 175
FAIR INFORMATION PRACTICES AND PUBLIC RECORDS

CHAPTER 176
CRITERIA FOR AWARDS OR GRANTS

CHAPTER 177
HEALTH DATA

CHAPTER 178
VARIANCES AND WAIVERS OF PUBLIC HEALTH ADMINISTRATIVE RULES

CHAPTER 179
COLLECTION OF DELINQUENT DEBTS

CHAPTERS 180 to 185
Reserved

CHAPTER 186
GOVERNMENTAL PUBLIC HEALTH ADVISORY BODIES

CHAPTERS 187 to 190
Reserved

CHAPTER 191
ADVISORY BODIES OF THE DEPARTMENT

CHAPTER 192
CHILD SUPPORT NONCOMPLIANCE

CHAPTER 193
IMPAIRED PRACTITIONER REVIEW COMMITTEE

193.1(272C) Definitions
193.2(272C) Purpose
193.3(272C) Composition of the committee
193.4(272C) Eligibility
193.5(272C) Terms of participation in the impaired practitioner recovery program
193.6(272C) Limitations
193.7(272C) Confidentiality

CHAPTER 194
NONPAYMENT OF STATE DEBT

194.1(272D) Definitions
194.2(272D) Issuance or renewal of a license—denial
194.3(272D) Suspension or revocation of a license
194.4(272D) Sharing of information

CHAPTER 195
STUDENT LOAN DEFAULT/NONCOMPLIANCE WITH AGREEMENT FOR PAYMENT OF OBLIGATION

195.1(261) General definitions
195.2(261) Issuance or renewal of a license—denial
195.3(261) Suspension or revocation of a license
195.4(17A,22,261) Sharing of information

CHAPTER 196
MILITARY SERVICE AND VETERAN RECIPROCITY

196.1(85GA,ch1116) Definitions
196.2(85GA,ch1116) Military education, training, and service credit
196.3(85GA,ch1116) Veteran reciprocity

CHAPTERS 197 to 200
Reserved

CHAPTER 201
ORGANIZED DELIVERY SYSTEMS

LICENSURE AND REGULATION

201.1(135,75GA,ch158) Purpose and scope
201.2(135,75GA,ch158) Definitions
201.3(135,75GA,ch158) Application
201.4(135,75GA,ch158) Governing body
201.5(135,75GA,ch158) Service area/geographic access
201.6(135,75GA,ch158,78GA,ch41) Provider network and contracts; treatment and services
201.7(135,75GA,ch158) Complaints
201.8(135,75GA,ch158) Accountability
201.9(135,75GA,ch158) Reporting
201.10(135,75GA,ch158) Evaluation
201.11(135,75GA,ch158) Annual report
201.12(135,75GA,ch158) Finance and solvency
201.13(135,75GA,ch158) Investment
201.14(135,75GA,ch158) Rating practices
201.15(135,75GA,ch158) Name
201.16(135,75GA,ch158) Change in organizational documents or control

CHAPTER 206
IOWA HEALTH INFORMATION NETWORK

CHAPTER 7
IMMUNIZATION AND IMMUNIZATION EDUCATION: PERSONS ATTENDING ELEMENTARY OR SECONDARY SCHOOLS, LICENSED CHILD CARE CENTERS OR INSTITUTIONS OF HIGHER EDUCATION

[Prior to 7/29/87, Health Department[470]]

641—7.1(139A) Definitions.

"Admitting official" means the superintendent of schools or the superintendent's designated representative if a public school; if a nonpublic school or licensed child care center, the governing official of the school or child care center.

"Advanced registered nurse practitioner" or *"ARNP"* means an advanced registered nurse practitioner as defined in 655—7.1(152).

"Applicant" means any person seeking enrollment in a licensed child care center or elementary or secondary school.

"Certified medical assistant" means a person who is certified to practice as a certified medical assistant following completion of a postsecondary medical assistant program accredited by the Commission on Accreditation of Allied Health Education Programs or the Accrediting Bureau of Health Education Schools and successful completion of the certification examination and who is directed by a supervising physician, physician assistant, or nurse practitioner.

"Competent private instruction" means private instruction as defined by the department of education pursuant to Iowa Code section 299A.1.

"Department" means the Iowa department of public health.

"Electronic signature" means a confidential personalized digital key, code, or number that is used for secure electronic data transmission and that identifies and authenticates the signatory.

"Elementary school" means kindergarten if provided, and grades one through eight or grades one through six when grades seven and eight are included in a secondary school.

"Enrolled user" means a user of the registry who has completed an enrollment form that specifies the conditions under which the registry can be accessed and who has been issued an identification code and password by the department.

"Health screening" means a vision screen, dental screen, or refugee health screen.

"Immunization registry" or *"registry"* means the database and file server maintained by the department as well as the software application that allows enrolled users to exchange immunization or health screening records.

"Institution of higher education" means a postsecondary school.

"Licensed child care center" means a facility or program licensed by the Iowa department of human services to provide child care for seven or more children or a prekindergarten or preschool, regardless of the source of funding, operated by a local school district, an accredited nonpublic school, an area education agency, or a college or university.

"Nurse" means a person licensed to practice as a nurse pursuant to Iowa Code chapter 152.

"On-campus residence hall or dormitory" means campus housing for students that is owned or leased by the institution of higher education and located on a recognized campus site.

"Pharmacist" means a person licensed to practice pharmacy pursuant to Iowa Code chapter 155A.

"Physician" means a person licensed to practice medicine and surgery or osteopathic medicine and surgery pursuant to Iowa Code chapter 148.

"Physician assistant" means a person licensed to practice as a physician assistant pursuant to Iowa Code chapter 148C.

"Postsecondary school" means a postsecondary institution under the control of the state board of regents, a community college established under Iowa Code chapter 260C, or an accredited private institution as defined in Iowa Code section 261.9, subsection 1.

"Postsecondary student" means a person who has officially registered with a postsecondary school, as determined by the school, and who physically attends class on the school's campus. For purposes of these rules, "postsecondary student" does not include a person who is exclusively registered in a

correspondence course or continuing education class or who attends class exclusively by means of the Internet or the Iowa communications network or through other means which do not require the person's physical presence on the school's campus.

"Provisional enrollment" means enrollment for a period of time not to exceed the limit specified in subrule 7.7(2) to allow the applicant to meet the requirements of these rules. A provisionally enrolled applicant is entitled access to all the benefits, activities, and opportunities of the school or licensed child care center. Provisional enrollment shall not deny the school funding for the applicant.

"Screening provider" means an ophthalmologist, optometrist, pediatrician, physician, free clinic, child care center, local public health department, public or accredited nonpublic school, community-based organization, advanced registered nurse practitioner (ARNP), physician assistant, dentist or dental hygienist.

"Secondary school" means (a) a junior high school comprising grades 7, 8 and 9, and a senior high school; (b) a combined junior-senior high school comprising grades 7 through 12; (c) a junior high school comprising grades 7 and 8 and a high school comprising grades 9 through 12; (d) a high school comprising grades 9 through 12.

"Signature" means an original signature or the authorized use of a stamped signature or electronic signature.

"Student" means an individual who is enrolled in a licensed child care center, elementary school or secondary school.

[**ARC 0481C**, IAB 12/12/12, effective 1/16/13; **ARC 1477C**, IAB 6/11/14, effective 7/16/14; **ARC 2390C**, IAB 2/3/16, effective 3/9/16; **ARC 2836C**, IAB 12/7/16, effective 1/11/17]

641—7.2(139A) Persons included. The immunization requirements specified elsewhere in these rules apply to all persons enrolled or attempting to enroll in a licensed child care center or a public or nonpublic elementary or secondary school in Iowa including those who are provided competent private instruction.

641—7.3(139A) Persons excluded. Exclusions to these rules are permitted on an individual basis for medical and religious reasons. Applicants approved for medical or religious exemptions shall submit to the admitting official a valid Iowa department of public health certificate of immunization exemption.

7.3(1) To be valid, a certificate of immunization exemption for medical reasons shall contain, at a minimum, the applicant's last name, first name, and date of birth, the vaccine(s) exempted, and an expiration date (if applicable) and shall bear the signature of a physician, nurse practitioner, or physician assistant. A medical exemption may be granted to an applicant when, in the opinion of a physician, nurse practitioner, or physician assistant:

a. The required immunizations would be injurious to the health and well-being of the applicant or any member of the applicant's family or household. In this circumstance, a medical exemption may apply to a specific vaccine(s) or all required vaccines. If, in the opinion of the physician, nurse practitioner, or physician assistant issuing the medical exemption, the exemption should be terminated or reviewed at a future date, an expiration date shall be recorded on the certificate of immunization exemption; or

b. Administration of the required vaccine would violate minimum interval spacing. In this circumstance, an exemption shall apply only to an applicant who has not received prior doses of the exempted vaccine. An expiration date, not to exceed 60 calendar days, and the name of the vaccine exempted shall be recorded on the certificate of exemption.

7.3(2) A religious exemption may be granted to an applicant if immunization conflicts with a genuine and sincere religious belief.

a. To be valid, a certificate of immunization exemption for religious reasons shall contain, at a minimum, the applicant's last name, first name, and date of birth and shall bear the signature of the applicant or, if the applicant is a minor, of the applicant's parent or guardian and shall attest that immunization conflicts with a genuine and sincere religious belief and that the belief is in fact religious and not based merely on philosophical, scientific, moral, personal, or medical opposition to immunizations.

b. The certificate of immunization exemption for religious reasons is valid only when notarized.

7.3(3) Medical and religious exemptions under this rule do not apply in times of emergency or epidemic as determined by the state board of health and declared by the director of public health.

641—7.4(139A) Required immunizations.

7.4(1) Applicants enrolled or attempting to enroll shall have received the following vaccines in accordance with the doses and age requirements below:

IMMUNIZATION REQUIREMENTS

Applicants enrolled or attempting to enroll shall have received the following vaccines in accordance with the doses and age requirements listed below. If, at any time, the age of the child is between the listed ages, the child must have received the number of doses in the "Total Doses Required" column.

Institution	Age	Vaccine	Total Doses Required
Licensed Child Care Center	Less than 4 months of age	This is not a recommended administration schedule, but contains the minimum requirements for participation in licensed child care. **Routine vaccination begins at 2 months of age.**	
	4 months through 5 months of age	Diphtheria/Tetanus/Pertussis	1 dose
		Polio	1 dose
		haemophilus influenzae type B	1 dose
		Pneumococcal	1 dose
	6 months through 11 months of age	Diphtheria/Tetanus/Pertussis	2 doses
		Polio	2 doses
		haemophilus influenzae type B	2 doses
		Pneumococcal	2 doses
	12 months through 18 months of age	Diphtheria/Tetanus/Pertussis	3 doses
		Polio	2 doses
		haemophilus influenzae type B	2 doses if the applicant received 1 dose before 15 months of age; or 1 dose if received when the applicant is 15 months of age or older.
		Pneumococcal	3 doses if the applicant received 1 or 2 doses before 12 months of age; or 2 doses if the applicant has not received any previous doses or has received 1 dose on or after 12 months of age.
	19 months through 23 months of age	Diphtheria/Tetanus/Pertussis	4 doses
		Polio	3 doses
		haemophilus influenzae type B	3 doses, with the final dose in the series received on or after 12 months of age; or 2 doses if only 1 dose received before 15 months of age; or 1 dose if received when the applicant is 15 months of age or older.
		Pneumococcal	4 doses if the applicant received 3 doses before 12 months of age; or 3 doses if the applicant received 1 or 2 doses before 12 months of age; or 2 doses if the applicant has not received any previous doses or has received 1 dose on or after 12 months of age.
		Measles/Rubella[1]	1 dose of measles/rubella-containing vaccine received on or after 12 months of age; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Varicella	1 dose received on or after 12 months of age, unless the applicant has a reliable history of natural disease.
	24 months of age and older	Diphtheria/Tetanus/Pertussis	4 doses
		Polio	3 doses
		haemophilus influenzae type B	3 doses, with the final dose in the series received on or after 12 months of age; or 2 doses if only 1 dose received before 15 months of age; or 1 dose if received when the applicant is 15 months of age or older. **Hib vaccine is not required for persons 60 months of age or older.**
		Pneumococcal	4 doses if the applicant received 3 doses before 12 months of age; or 3 doses if the applicant received 2 doses before 24 months of age; or 2 doses if the applicant received 1 dose before 24 months of age; or 1 dose if the applicant did not receive any doses before 24 months of age. **Pneumococcal vaccine is not required for persons 60 months of age or older.**
		Measles/Rubella[1]	1 dose of measles/rubella-containing vaccine received on or after 12 months of age; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Varicella	1 dose received on or after 12 months of age, unless the applicant has had a reliable history of natural disease.
Elementary or Secondary School (K-12)	4 years of age and older	Diphtheria/Tetanus/ Pertussis[4, 5]	3 doses, with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born on or before September 15, 2000[2]; or 4 doses, with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born after September 15, 2000, but on or before September 15, 2003[2]; or 5 doses with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born after September 15, 2003[2, 3]; and 1 time dose of tetanus/diphtheria/acellular pertussis-containing vaccine (Tdap) for the applicant in grades 7 and above, if born after September 15, 2000; regardless of the interval since the last tetanus/diphtheria-containing vaccine.
		Polio	3 doses, with at least 1 dose received on or after 4 years of age if the applicant was born on or before September 15, 2003[7]; or 4 doses, with at least 1 dose received on or after 4 years of age if the applicant was born after September 15, 2003.[6] **Polio vaccine is not required for persons 18 years of age or older.**
		Measles/Rubella[1]	2 doses of measles/rubella-containing vaccine; the first dose shall have been received on or after 12 months of age; the second dose shall have been received no less than 28 days after the first dose; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Hepatitis B	3 doses
		Varicella	1 dose received on or after 12 months of age if the applicant was born on or after September 15, 1997, but born on or before September 15, 2003, unless the applicant has had a reliable history of natural disease; or 2 doses received on or after 12 months of age if the applicant was born after September 15, 2003, unless the applicant has a reliable history of natural disease.[8]
		Meningococcal (A, C, W, Y)	1 dose of meningococcal vaccine received on or after 10 years of age for the applicant in grades 7 and above, if born after September 15, 2004; and 2 doses of meningococcal vaccine for the applicant in grade 12, if born after September 15, 1999; or 1 dose if received when the applicant is 16 years of age or older.

[1] Mumps vaccine may be included in measles/rubella-containing vaccine.
[2] DTaP is not indicated for persons 7 years of age or older, therefore, a tetanus and diphtheria-containing vaccine should be used.
[3] The 5th dose of DTaP is not necessary if the 4th dose was administered on or after 4 years of age.
[4] Applicants 7 through 18 years of age who received their 1st dose of diphtheria/tetanus/pertussis-containing vaccine before 12 months of age should receive a total of 4 doses, with one of those doses administered on or after 4 years of age.
[5] Applicants 7 through 18 years of age who received their 1st dose of diphtheria/tetanus/pertussis-containing vaccine at 12 months of age or older should receive a total of 3 doses, with one of those doses administered on or after 4 years of age.
[6] If an applicant received an all-inactivated poliovirus (IPV) or all-oral poliovirus (OPV) series, a 4th dose is not necessary if the 3rd dose was administered on or after 4 years of age.
[7] If both OPV and IPV were administered as part of the series, a total of 4 doses are required.
[8] Administer 2 doses of varicella vaccine, at least 3 months apart, to applicants less than 13 years of age. Do not repeat the 2nd dose if administered 28 days or greater from the 1st dose. Administer 2 doses of varicella vaccine to applicants 13 years of age or older at least 4 weeks apart. The minimum interval between the 1st and 2nd dose of varicella for an applicant 13 years of age or older is 28 days.

7.4(2) Vaccine doses administered less than or equal to 4 days before the minimum interval or age shall be counted as valid. Doses administered greater than or equal to 5 days earlier than the minimum interval or age shall not be counted as valid doses and shall be repeated as appropriate.

7.4(3) For vaccine administration, the minimum age and intervals recommended by the advisory committee on immunization practices shall be followed.

[**ARC 8377B**, IAB 12/16/09, effective 11/18/09; **ARC 8658B**, IAB 4/7/10, effective 5/12/10; **ARC 0481C**, IAB 12/12/12, effective 1/16/13; **ARC 0586C**, IAB 2/6/13, effective 1/16/13; **ARC 2836C**, IAB 12/7/16, effective 1/11/17]

641—7.5(139A) Required education. Each institution of higher education that has an on-campus residence hall or dormitory shall provide vaccination information on meningococcal disease to each postsecondary student enrolled in the institution of higher education. Meningococcal disease information shall be contained on student health forms. For purposes of this rule, student health form(s) means a document(s) prepared by an institution of higher education that contains, at a minimum, information on meningococcal disease, vaccination information and any recommendations issued by the national Centers for Disease Control and Prevention regarding meningococcal disease. The student health form(s) shall also include space for the postsecondary student to indicate whether or not the postsecondary student has received vaccination against meningococcal disease, including, at a minimum, the date of vaccination. The student health form(s) shall also include space for the postsecondary student to indicate whether or not the postsecondary student has received information on meningococcal disease and benefits of vaccine. If a traditional student health form is not utilized by the institution of higher education, any document(s) containing the above information is acceptable.

641—7.6(139A) Proof of immunization.

7.6(1) A valid Iowa department of public health certificate of immunization shall be submitted by the applicant or, if the applicant is a minor, by the applicant's parent or guardian to the admitting official of the school or licensed child care center in which the applicant wishes to enroll. To be valid, the certificate shall be the certificate of immunization issued by the department, a computer-generated copy from the immunization registry, or a certificate of immunization which has been approved in writing by the department. The certificate shall contain, at a minimum, the applicant's last name, first name, and date of birth, the vaccine(s) administered, the date(s) given, and the signature of a physician, a physician assistant, a nurse, or a certified medical assistant. A faxed copy, photocopy, or electronic copy of the valid certificate is acceptable. The judgment of the adequacy of the applicant's immunization history should be based on records kept by the person signing the certificate of immunization or on that person's personal knowledge of the applicant's immunization history, or comparable immunization records from another person or agency, or an international certificate of vaccination, or the applicant's personal health records. If personal health records are used to make the judgment, the records shall include the vaccine(s) administered and the date given. Persons validating the certificate of immunization are not held responsible for the accuracy of the information used to validate the certificate of immunization if the information is from sources other than their own records or personal knowledge.

7.6(2) Persons wishing to enroll who do not have a valid Iowa department of public health certificate of immunization available to submit to the admitting official shall be referred to a physician, a physician assistant, a nurse, or a certified medical assistant to obtain a valid certificate.

641—7.7(139A) Provisional enrollment.

7.7(1) A valid Iowa department of public health provisional enrollment certificate shall be submitted by the applicant or, if the applicant is a minor, by the applicant's parent or guardian to the admitting

official of the school or licensed child care center in which the applicant wishes to enroll. Applicants who have begun but not completed the required immunizations may be granted provisional enrollment. To qualify for provisional enrollment, applicants shall have received at least one dose of each of the required vaccines or be a transfer student from another school system. A transfer student is an applicant seeking enrollment from one United States elementary or secondary school into another. To be valid, the certificate shall be the certificate of immunization issued by the department, a computer-generated copy from the immunization registry, or a certificate of immunization which has been approved in writing by the department. The certificate shall contain, at a minimum, the applicant's last name, first name, and date of birth, the vaccine(s) administered, the date(s) given, the remaining vaccine(s) required, the reason that the applicant qualifies for provisional enrollment, and the signature of a physician, a physician assistant, a nurse, or a certified medical assistant. Persons validating the provisional certificate of immunization are not held responsible for the accuracy of the information used to validate the provisional certificate of immunization if the information is from sources other than their own records or personal knowledge. Persons signing the provisional certificate of immunization shall certify that they have informed the applicant or, if the applicant is a minor, the applicant's parent or guardian of the provisional enrollment requirements.

a. Any applicant seeking provisional enrollment who does not have a valid Iowa department of public health provisional certificate of immunization to submit to the admitting official shall be referred to a physician, a physician assistant, a nurse, or a certified medical assistant to obtain a valid certificate.

b. Reserved.

7.7(2) The amount of time allowed for provisional enrollment shall be as soon as medically feasible but shall not exceed 60 calendar days. The period of provisional enrollment shall begin on the date the provisional certificate is signed. The person signing the provisional certificate shall assign an expiration date to the certificate and shall indicate the remaining immunizations required to qualify for a certificate of immunization.

7.7(3) The applicant or parent or guardian shall ensure that the applicant receive the necessary immunizations during the provisional enrollment period and shall submit a certificate of immunization to the admitting official by the end of the provisional enrollment period.

7.7(4) Rescinded IAB 12/3/08, effective 1/7/09.

7.7(5) If at the end of the provisional enrollment period the applicant or parent or guardian has not submitted a certificate of immunization, the admitting official shall immediately exclude the applicant from the benefits, activities, and opportunities of the school or licensed child care center until the applicant or parent or guardian submits a valid certificate of immunization.

7.7(6) If at the end of the provisional enrollment period the applicant has not completed the required immunizations due to minimum interval requirements, a new Iowa department of public health provisional certificate of immunization shall be submitted to the admitting official. The admitting official must maintain all issued certificates of provisional immunization with the original provisional certificate until the applicant submits a certificate of immunization.

[**ARC 0481C**, IAB 12/12/12, effective 1/16/13]

641—7.8(139A) Records and reporting.

7.8(1) It shall be the duty of the admitting official of a licensed child care center or elementary or secondary school to ensure that the admitting official has a valid Iowa department of public health certificate of immunization, certificate of immunization exemption, or provisional certificate of immunization on file for each student.

a. The admitting official shall keep the certificates on file in the school or licensed child care center in which the student is enrolled and assist the student or parent or guardian in the transfer of the certificate to another school or licensed child care center upon the transfer of the student to another school or licensed child care center.

b. Unless otherwise requested by the applicant, or parent or guardian, the admitting official shall retain the Iowa department of public health certificate of immunization, or certificate of immunization exemption, or provisional certificate of immunization for three years commencing upon the transfer or

graduation of the applicant or the school may choose to provide the permanent immunization record to the student at time of graduation. Included with the immunization record a letter should state that this is an important document that will be needed by the student for college or employment and should be permanently retained.

7.8(2) It shall be the duty of the local boards of health to audit the Iowa department of public health certificates of immunization, certificates of immunization exemption, and provisional certificates of immunization in the schools within their jurisdiction to determine compliance with Iowa Code section 139A.8. The local boards of health shall furnish the Iowa department of public health within 60 days of the first official day of school a report of the audit. The report shall be submitted for each school within the local board of health's jurisdiction and shall include the enrollment by grade, and the number of Iowa department of public health certificates of immunization, certificates of immunization exemption, and provisional certificates of immunization by grade.

7.8(3) The local board of health and the Iowa department of public health shall have the right to have access to the Iowa department of public health certificates of immunization, certificates of immunization exemption, and the provisional certificates of immunization of children enrolled in elementary and secondary schools and licensed child care centers within the constraints of the privacy rights of parents and students.

7.8(4) The admitting official of an institution of higher education shall provide to the department of public health by December 1 each year aggregate data regarding compliance with Iowa Code section 139A.26. The data shall be forwarded to the department within 30 days. The data shall include, but not be limited to, the total number of incoming postsecondary freshmen students living in a residence hall or dormitory who have:

a. Enrolled in the institution of higher education; and

b. Been provided information on meningococcal disease; and

c. Been immunized with meningococcal vaccine.

641—7.9(139A) Providing immunization services. It shall be the duty of the local boards of health to provide immunization services where no local provision exists for the services.

641—7.10(139A) Compliance. Applicants not presenting proper evidence of immunization, or exemption, are not entitled to enrollment in a licensed child care center or elementary or secondary school under the provisions of Iowa Code section 139A.8. It shall be the duty of the admitting official to deny enrollment to any applicant who does not submit proper evidence of immunization according to rule 641—7.6(139A) and to exclude a provisionally enrolled applicant in accordance with rule 641—7.7(139A).

641—7.11(22) Statewide registry.

7.11(1) *Statewide registry.* The department shall maintain a statewide immunization and health screening registry. Enrolled users are responsible for purchasing and maintaining all computer hardware related to use of the registry and for providing an Internet connection to transfer information between the user's computer and the registry.

7.11(2) *Purpose and permitted uses of registry.*

a. The registry shall contain immunization and health screening information, including identifying and demographic data, to allow enrolled users to maintain and access a database of immunization and health screening histories for purposes of ensuring that patients are fully immunized and screened.

b. The registry may be used to track inventory or utilization of pharmaceutical agents identified by the department to prepare for or respond to an emergency event.

c. Enrolled users shall not use information obtained from the registry to market services to patients or nonpatients, to assist in bill collection services, or to locate or identify patients or nonpatients for any purpose other than those expressly provided in this rule.

d. The registry shall contain health screening data, including screening results and follow-up information.

7.11(3) *Release of information to the registry.* Enrolled users shall provide immunization and health screening information, including identifying and demographic data, to the registry. Information provided may include, but is not limited to, the following:

a. Name of patient;
b. Gender of patient;
c. Date of birth;
d. Race;
e. Ethnicity;
f. Birth state and birth country;
g. Address;
h. Parents' names;
i. Mother's maiden name;
j. Type of vaccination administered;
k. Dose or series number of vaccine;
l. Date vaccination was administered;
m. Lot number;
n. Date of health screening;
o. Health screening results;
p. Source of health screening;
q. Health screening follow-up information;
r. Patient comments;
s. Provider name, license, and business address; and
t. Patient history, including previously unreported doses.

7.11(4) *Confidentiality of registry information.* Immunization and health screening information, including identifying and demographic data maintained on the registry, is confidential and may not be disclosed except under the following limited circumstances:

a. The department may release information from the registry to the following:

(1) The person or the parent or legal guardian of the person immunized or screened.

(2) Enrolled users of the registry who have completed an enrollment form that specifies the conditions under which the registry can be accessed and who have been issued an organization code and user name by the department;

(3) Persons or entities requesting immunization or health screening data in an aggregate form that does not identify an individual either directly or indirectly.

(4) Agencies that complete an agreement with the department which specifies conditions for access to registry data and how that data will be used. Agencies shall not use information obtained from the registry to market services to patients or nonpatients, to assist in bill collection services, or to locate or identify patients or nonpatients for any purposes other than those expressly provided in this rule.

(5) A representative of a state or federal agency, or entity bound by that state or federal agency, to the extent that the information is necessary to perform a legally authorized function of that agency or the department. The state or federal agency is subject to confidentiality regulations that are the same as or more stringent than those in the state of Iowa. State or federal agencies shall not use information obtained from the registry to market services to patients or nonpatients, to assist in bill collection services, or to locate or identify patients or nonpatients for any purposes other than those expressly provided in this rule.

(6) The admitting official of a licensed child care center, elementary school, secondary school, or postsecondary school; or medical or health care providers providing continuity of care.

(7) Enrolled users from other states or jurisdictions who have signed and completed enrollment in the state's or jurisdiction's immunization registry.

b. Enrolled users shall not release data obtained from the registry except to the person or the parent or legal guardian of the person immunized or screened, admitting officials of licensed child care centers

and schools, medical or health care providers providing continuity of care, and other enrolled users of the registry.

7.11(5) *Suspend or terminate access.* The department may suspend or terminate an enrolled user's access consistent with department policy if the user violates this chapter, the IRIS Authorized Site Agreement-Organization, the IRIS Authorized Individual User Agreement, or the IRIS Security and Confidentiality Policy. The department shall approve, suspend, terminate, and reinstate user access in accordance with this chapter and department policy.

[**ARC 8377B**, IAB 12/16/09, effective 11/18/09; **ARC 8658B**, IAB 4/7/10, effective 5/12/10; **ARC 0481C**, IAB 12/12/12, effective 1/16/13; **ARC 1477C**, IAB 6/11/14, effective 7/16/14; **ARC 2836C**, IAB 12/7/16, effective 1/11/17]

641—7.12(22) Release of immunization and health screening information.

7.12(1) *Between a physician, physician assistant, nurse, certified medical assistant, pharmacist, or screening provider and the elementary, secondary, or postsecondary school or licensed child care center that the student attends.* A physician, a physician assistant, a nurse, a certified medical assistant, a pharmacist, or a screening provider shall disclose a student's or patient's immunization or health screening information, including the name, date of birth, and demographic information; vaccine(s) administered and the month, day and year of administration; health screening results; and clinic source and location, to an elementary, secondary, or postsecondary school or a licensed child care center upon written or verbal request from the elementary, secondary, or postsecondary school or licensed child care center. Written or verbal permission from a student or parent is not required to release this information to an elementary, secondary, or postsecondary school or licensed child care center that the student attends.

7.12(2) *Among physicians, physician assistants, nurses, certified medical assistants, pharmacists or screening providers.* Immunization or health screening information, including the student's or patient's name, date of birth, and demographic information; vaccine(s) administered and the month, day and year of administration; health screening results; and clinic source and location, shall be provided by a physician, physician assistant, nurse, certified medical assistant, pharmacist, or screening provider to another health care provider without written or verbal permission from the student, parent, guardian or patient.

7.12(3) *Among an elementary school, secondary school, postsecondary school, and licensed child care center that the student attends.* An elementary school, secondary school, postsecondary school, and licensed child care center shall disclose a student's immunization or health screening information, including the student's name, date of birth, and demographic information; vaccine(s) administered and the month, day and year of administration; health screening results; and clinic source and location, to another elementary school, secondary school, postsecondary school, and licensed child care center that the student attends. Written or verbal permission from a student, or if the student is a minor, the student's parent or guardian, is not required to release this information to an elementary school, secondary school, postsecondary school, and licensed child care center that the student attends.

7.12(4) *Among the department and a physician, physician assistant, nurse, certified medical assistant, pharmacist, screening provider, elementary school, secondary school, postsecondary school, and licensed child care center.* A student's or patient's immunization or health screening information, including name, date of birth, grade, and demographic information; vaccine(s) administered and the month, day and year of administration; and health screening results, clinic source, and location, all in a format specified by the department, shall be disclosed upon written or verbal request among the department, physicians, physician assistants, nurses, certified medical assistants, pharmacists, screening providers, elementary schools, secondary schools, postsecondary schools, and licensed child care centers. Written or verbal permission from a student, patient, parent, or guardian is not required to release this information.

7.12(5) *Among the department and physicians, physician assistants, nurses, resettlement agencies, federal, state, and local government agencies, and certified medical assistants conducting refugee health screenings.* Refugee health screenings shall be disclosed only as indicated in this rule. Immunization or health screening information, including the patient's name, date of birth, and demographic information;

the vaccine(s) administered and the month, day, and year of administration; health screening results; and clinic source and location, shall be disclosed upon written or verbal request among the department, physicians, physician assistants, nurses, certified medical assistants, resettlement agencies, federal, state, and local government agencies, or screening providers to another health care provider or the department. Written or verbal permission from the parent, guardian or patient is not required to release this information.

[**ARC 0481C**, IAB 12/12/12, effective 1/16/13; **ARC 1477C**, IAB 6/11/14, effective 7/16/14; **ARC 2390C**, IAB 2/3/16, effective 3/9/16; **ARC 2836C**, IAB 12/7/16, effective 1/11/17]

These rules are intended to implement Iowa Code sections 139A.8 and 22.7(2).

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◊ Two or more ARCs

CHAPTER 26
BACKFLOW PREVENTION ASSEMBLY TESTER REGISTRATION

641—26.1(135K) Applicability. This chapter applies to all persons who test or repair backflow prevention assemblies in Iowa.

641—26.2(135K) Definitions.

"ABPA" means the American Backflow Prevention Association.

"Administrative authority" means an individual, board, department, or agency employed by a city, county or other political subdivision of the state and authorized by local ordinance to administer and enforce the provisions of the plumbing code.

"Approved continuing education course" means a department-approved course that is designed to supplement or refresh the knowledge of a registered tester and to meet the requirements of subparagraph 26.5(2)*"a"*(2).

"Approved training course" means a department-approved course that is designed to train individuals to test and repair backflow prevention assemblies.

"ASSE" means the American Society of Sanitary Engineering.

"AWWA" means the American Water Works Association.

"Backflow prevention assembly," for the purposes of this chapter, means a device or means to prevent backflow into a potable water system for which a method of testing the device in-line has been published by the Foundation of Cross-Connection Control and Hydraulic Research at the University of Southern California.

NOTE: The following assemblies are included under this definition. This is not intended to be an exclusive list. If new devices and test methods are introduced that meet the definition, they are included under the rules.

Backflow Prevention Assembly	Product Standards
Double Check Valve Assembly	ASSE 1015-2011, AWWA C510-07
Double Check Detector Assembly	ASSE 1048-2011
Pressure Vacuum Breaker	ASSE 1020-2011
Reduced Pressure Principle Backflow Preventer	ASSE 1013-2011, AWWA 511-07
Reduced Pressure Detector Assembly	ASSE 1047-2011
Spill Resistant Pressure Vacuum Breaker	ASSE 1056-2013

"Certified" as used in these rules means certified as a backflow prevention assembly tester under the requirements of ABPA or another third-party certification agency.

"Department" means the Iowa department of public health.

"Proctor" means an individual designated by a third-party certification agency to conduct certification examinations of backflow prevention assembly testers.

"Registered backflow prevention assembly tester" or *"registered tester"* means a person who has successfully completed an approved training course, or who is certified, and who has registered with the department in accordance with 641—26.5(135K).

"Third-party certification agency" means the ABPA, ASSE or another agency approved by the department to certify the knowledge and skills of backflow prevention assembly testers.

[**ARC 8981B**, IAB 8/11/10, effective 9/15/10; **ARC 2837C**, IAB 12/7/16, effective 1/11/17]

641—26.3(135K) Registration required. No person shall test or repair a backflow prevention assembly unless the person is a registered backflow prevention assembly tester.

641—26.4(135K) Backflow prevention assembly tester training.

26.4(1) *Tester training.*

a. A person or organization that plans to conduct or sponsor a backflow prevention assembly tester training course in Iowa shall apply to the department for approval of the course at least 15 days before the first time the course is held. The application shall include:

(1) Sponsoring organization name and Web site URL (if any), contact person, mailing address, E-mail address and telephone number.

(2) Course dates and times, if a course has been scheduled.

(3) Course location, including street address, if a course has been scheduled.

(4) Course outline, including the approximate time allotted to each training segment.

(5) A list of reference materials, texts and audio-visual materials used in the course.

(6) A copy of the written examination for the course and a written description of the elements and standards of proficiency for the practical examination.

(7) The name(s) and qualifications of the instructor(s).

(8) A list of the backflow prevention assemblies available for classwork and the number of test stations available for the students.

(9) The maximum class size.

(10) A $200 nonrefundable fee. A $15 returned check fee will be charged for each check returned for insufficient funds.

b. The department shall review the application and respond to the applicant within 10 business days after the department receives the application.

c. The person or organization responsible for the course content shall submit to the department the information required in paragraph 26.4(1)*"a"* within 30 calendar days of the fifth anniversary of the initial approval by the department and within 30 calendar days of the anniversary date of each fifth year thereafter.

d. The course sponsor shall notify the department at least 15 days before an approved training course is started. The notification shall include:

(1) Sponsoring organization name and Web site URL (if any), contact person, mailing address, E-mail address, and telephone number.

(2) Course dates and times.

(3) Course location, including street address.

(4) A $50 nonrefundable fee. A $15 returned check fee will be charged for each check returned for insufficient funds.

e. A training course shall be at least 32 instructional hours.

(1) The training course shall cover at least the following subjects:

1. Backflow definitions, causes and examples.

2. Description of backflow prevention assemblies, their proper application and installation, and their operational characteristics.

3. Description and operational characteristics of test equipment.

4. Techniques for testing backflow prevention assemblies.

5. Troubleshooting of backflow prevention assemblies.

6. Record keeping and the responsibilities of regulatory agencies and the registered tester.

(2) The course shall conclude with a written examination of at least 100 questions and a practical examination of testing techniques on all types of testable backflow prevention assemblies. The time for testing shall be in addition to the required instructional hours. To have successfully completed the course, the student must achieve a passing mark of at least 70 percent on the written examination and demonstrate proficiency in testing and troubleshooting procedures.

(3) Approved third-party certification agency testing may be substituted for the course test.

f. The lead course instructor shall:

(1) Have successfully completed an approved training course, document the successful completion of a course that meets the requirements of an approved training course, or be certified.

(2) Have at least three years of experience in cross connection control.

g. Backflow prevention assembly testing instruction laboratory.

(1) The testing laboratory for a training course shall be equipped with examples of each of the backflow prevention assemblies from at least three different manufacturers. If fewer than three manufacturers make a type of backflow prevention assembly, at least one example of that type of backflow prevention assembly shall be provided. At least one double check valve assembly and one reduced pressure principle assembly larger than two inches shall be provided.

(2) The testing laboratory shall provide at least one test station per three students.

26.4(2) *Continuing education training.*

a. A person or organization that plans to conduct or sponsor a continuing education course for registered testers in Iowa shall apply to the department for approval of the course at least 15 days before the course is scheduled to begin. The application shall include:

(1) Sponsoring organization name and Web site URL (if any), contact person, mailing address, E-mail address, and telephone number.

(2) Course date and time.

(3) Course location, including street address.

(4) Course outline, including the approximate time allotted to each training segment.

(5) A list of reference materials, texts and audio-visual materials used in the course.

(6) A list of backflow prevention assemblies that will be used for the course (if applicable).

(7) The name(s) and qualifications of the instructor(s).

(8) A $50 nonrefundable fee. A $15 returned check fee will be charged for each check returned for insufficient funds.

b. The department shall review the application and respond to the applicant within ten business days after the department receives the application.

c. A continuing education course shall be on cross connection control theory and practice; backflow prevention devices and methods; backflow prevention assembly installation, testing, troubleshooting and repair; codes and rules affecting cross connection control; safety issues related to installation and testing of backflow prevention assemblies; or related subjects approved by the department.

26.4(3) *Third-party certification agencies.*

a. An agency that wishes to be a third-party certification agency in Iowa shall submit to the department a request for approval in writing on agency letterhead, signed by an authorized representative of the agency. The request shall include at least the following:

(1) Agency name and Web site URL (if any), contact person, mailing address, E-mail address, and telephone number.

(2) A description of the written examination and whether it is open- or closed-book and information about the arrangements for administration of the examination.

(3) A copy of the testing procedures that are the basis for the practical examination.

(4) A description of the procedures for the practical examination and the criteria for evaluating the performance on the practical examination.

(5) Proctor qualifications and training.

(6) Procedures and criteria for renewing the certification. The renewal of certification shall be done at least every five years and shall include knowledge and skills testing.

(7) A history of the development and implementation of the program, as applicable.

(8) A list of other jurisdictions where the certification is allowed and regulatory contacts in those jurisdictions.

(9) A nonrefundable fee of $200. A $15 returned check fee will be charged for each check returned for insufficient funds.

b. A third-party certification agency shall not certify an individual who was trained by the agency. An individual proctor shall not certify individuals who have taken a course at which the proctor was an instructor.

c. A third-party certification agency shall submit to the department the information required in paragraph 26.4(3)*"a"* within 30 calendar days before the fifth anniversary of the initial approval by the department and on or within 30 calendar days before the anniversary date of every fifth year thereafter.
[**ARC 8981B**, IAB 8/11/10, effective 9/15/10; **ARC 2837C**, IAB 12/7/16, effective 1/11/17]

641—26.5(135K) Registration.

26.5(1) *Initial registration.*

a. A person who has successfully completed an approved training course may register with the department within the 12 months after the date of course completion. A person who is certified may register with the department. The applicant must submit:

(1) A completed application form (form provided by the department).

(2) Documentation of successful completion of an approved training course or documentation that the person is certified.

(3) A nonrefundable fee in accordance with Table 1. A $15 returned check fee will be charged for each check returned for insufficient funds.

The registration shall expire as shown in Table 1.

Table 1

Initial Registration Fees

Registration Month	Even Year		Odd Year	
	Fee	Registration Expiration	Fee	Registration Expiration
January - February	$66	October 31 + one year	$30	October 31
March - April	$60	October 31 + one year	$24	October 31
May - June	$54	October 31 + one year	$18	October 31
July - August	$48	October 31 + one year	$84	October 31 + two years
September - October	$42	October 31 + one year	$78	October 31 + two years
November - December	$36	October 31	$72	October 31 + one year

b. A person who has completed a course of training in another state may be registered in Iowa. The person shall submit:

(1) A completed Iowa application form (form provided by the department).

(2) Documentation that:

1. The person has successfully completed a training course that meets the hour and subject requirements for an approved training course (if the person completed the training course more than 12 months before the date of the application, the person shall document that the person has attended an average of at least 2.5 hours of continuing education training per year since completing the course), or

2. The person is certified, or

3. The person is registered as a backflow prevention assembly tester in a jurisdiction that has similar or greater requirements for training and continuing education than does the state of Iowa.

(3) A nonrefundable fee in accordance with Table 1. A $15 returned check fee will be charged for each check returned for insufficient funds.

The registration shall expire as shown in Table 1.

26.5(2) *Renewal registration.*

a. Except as provided in subrule 26.5(1), each registered tester shall renew the registration between July 1 and October 1 of each odd-numbered year. The registered tester shall submit:

(1) A completed registration renewal application form (form provided by the department).

(2) Documentation that the registered tester has completed at least five hours of approved continuing education courses after October 31 of the previous odd-numbered year or documentation that the registered tester is certified. Registered testers with an initial registration date of January 1 or later in an odd-numbered year are not required to obtain continuing education prior to renewal in that year.

(3) A nonrefundable fee of $72. A $15 returned check fee will be charged for each check returned for insufficient funds.

(4) Registration renewal applications received after October 1 shall include a $10 penalty per month or fraction thereof that the application is received after October 1 to a maximum of a $50 penalty.

b. Before a renewal may be issued for a registration that has lapsed for more than 24 months, the person applying for renewal of the registration shall document that one of the following conditions is true:

(1) The person has successfully completed an approved training course within the 12 months before applying for registration renewal, or

(2) The person is certified, or

(3) The person is registered as a backflow prevention assembly tester in a jurisdiction that has similar or greater requirements for training and continuing education than does the state of Iowa.

[**ARC 8981B**, IAB 8/11/10, effective 9/15/10; **ARC 2837C**, IAB 12/7/16, effective 1/11/17]

641—26.6(135K) Standards of conduct.

26.6(1) A registered tester shall comply with these rules and with the ordinances, rules and policies of the administrative authority in each jurisdiction in which the registered tester tests or repairs a backflow prevention assembly.

26.6(2) A registered tester shall maintain a record for each backflow prevention assembly tested for at least five years after the date on which the assembly was tested. Where required by ordinance, the registered tester shall submit to the administrative authority a completed test report on a form approved by the administrative authority. The record may be reviewed during normal business hours by an authorized representative of the department or by an authorized representative of the administrative authority of the jurisdiction in which the assembly is located. The assembly record shall include at least:

a. The name, address and telephone number of the assembly owner.

b. The location of the facility in which the assembly is located.

c. The location of the assembly within the facility.

d. The type, brand, model, size, and serial number of the assembly.

e. The date and time of the test.

f. Results of the test.

g. Any assembly repairs or maintenance.

26.6(3) A registered tester shall use a differential pressure gauge to field test a backflow prevention assembly. Methods of testing that use other types of equipment, such as but not limited to dual pressure gauges, water columns, or single pressure gauges, shall not be acceptable.

a. The accuracy of a differential pressure gauge used to test backflow prevention assemblies shall be verified no less frequently than every 13 months. The accuracy verification results shall be traceable to the National Institute of Standards and Technology (NIST). Any differential pressure gauge with an error of more than plus or minus 0.2 psi shall not be used to test a backflow prevention assembly.

b. For every test report record retained in accordance with the requirements of subrule 26.6(2), the most recent accuracy verification, for the differential pressure gauge used, performed prior to that test report date shall be retained.

c. The accuracy verification records shall be made available to an authorized representative of the department or by an authorized representative of the administrative authority of the jurisdiction in which the assembly is located.

[**ARC 2837C**, IAB 12/7/16, effective 1/11/17]

641—26.7(135K) Penalty. In addition to other sanctions provided in this chapter, a person who violates a provision of this chapter shall be guilty of a simple misdemeanor pursuant to the authority of Iowa Code section 135K.5.

[**ARC 2837C**, IAB 12/7/16, effective 1/11/17]

641—26.8(135K) Denial, probation, suspension or revocation. This rule pertains to denial, probation, suspension or revocation of registration; denial or revocation of training course approval; and denial or revocation of approval as a third-party certification agency.

26.8(1) The department may deny an application for registration or renewal, may place a registration on probation, may suspend or revoke a registration, or may order a registered tester not to test or repair backflow prevention assemblies when the department finds that the applicant or registered tester has committed any of the following acts:

a. Negligence or incompetence in the testing of a backflow prevention assembly, including failure to report improper application or installation of a backflow prevention assembly to the facility owner and the administrative authority.

b. Knowingly submitting a false report of a test of a backflow prevention assembly to the owner of the facility, the local administrative authority, or the department.

c. Fraud in obtaining registration or renewal including, but not limited to:

(1) Intentionally submitting false information on an application for registration or renewal;

(2) Submitting a false or forged certificate or other record of training or certification.

d. Falsification of the assembly records required by subrule 26.6(2).

e. Failure to comply with these rules and with the ordinances of an administrative authority in whose jurisdiction the registered tester tests a backflow prevention assembly.

f. Failure to pay a required registration, renewal or late fee.

g. Habitual intoxication or addiction to drugs.

h. Violating a statute of this state, another state, or the United States, without regard to its designation as either a felony or misdemeanor, which relates to backflow prevention assembly testing, including but not limited to crimes involving dishonesty, fraud, theft, controlled substances, substance abuse, assault, sexual abuse, sexual misconduct, or homicide. A copy of the record of conviction or plea of guilty is conclusive evidence of the violation.

i. Having the authorization to test backflow prevention assemblies suspended or revoked or having other disciplinary action taken by a licensing or certifying authority of another state, territory or country. A copy of the record or order of suspension, revocation or disciplinary action is conclusive evidence.

j. Knowingly making misleading, deceptive, untrue, or fraudulent representations regarding the testing of backflow prevention assemblies, or engaging in unethical conduct or practice harmful or detrimental to the public. Proof of actual injury need not be established. Acts which may constitute unethical conduct include, but are not be limited to:

(1) Verbally or physically abusing a client or coworker.

(2) Improper sexual contact with or making suggestive, lewd, lascivious, or improper remarks or advances to a client or coworker.

k. Engaging in any conduct that subverts or attempts to subvert a department investigation.

l. Failure to comply with a subpoena issued by the department or failure to cooperate with an investigation of the department.

m. Failure to comply with the terms of a department order or the terms of a settlement agreement or consent order.

n. Knowingly aiding, assisting or advising a person to unlawfully practice as a backflow prevention assembly tester.

o. Representing oneself as a registered backflow prevention assembly tester when one's registration has been suspended or revoked or when one's registration is lapsed or has been placed on inactive status.

p. Permitting the use of a registration by a nonregistered person for any purpose.

q. Acceptance of any fee by fraud or misrepresentation.

r. Failure to respond within 30 days of receipt, unless otherwise specified, of communication from the department which was sent by registered or certified mail.

26.8(2) The department may deny or revoke the approval for a training course or a continuing education course when it finds:

a. The lead instructor for a training course is not qualified in accordance with paragraph 26.4(1)*"f."*

b. The training course did not comply with paragraph 26.4(1)*"e."*

c. That the training course testing laboratory did not comply with paragraph 26.4(1)*"g."*

d. The organization or person applying for approval of a training or continuing education course intentionally submitted false information to the department in support of such approval.

e. The organization or person conducting or sponsoring training has falsified training or continuing education records, including issuance of a certificate or other record of training to a person who did not successfully complete a training course or who did not attend continuing education training.

f. The organization or person responsible for a training or continuing education course has permitted physical or verbal abuse or sexual harassment of a student or instructor. Sexual harassment includes sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

g. The organization or person responsible for training courses and continuing education courses consistently fails to notify the department of such courses in a timely fashion as required by 26.4(1)*"d"* and 26.4(2)*"a"* or fails to pay the required fee.

h. Failure to comply with these rules.

26.8(3) The department may deny or revoke the approval for a third-party certification agency when it finds:

a. The application for approval contains material misinformation regarding the conduct and standards of the certification program or its acceptance in other jurisdictions.

b. Failure to adhere to the standards and procedures stated in the application for approval in the process of certifying or renewing the certification of testers.

c. Violations of paragraph 26.4(3)*"b."*

d. Failure to comply with these rules.

26.8(4) Complaints. Complaints regarding a registered tester, an approved training course or a third-party certification agency shall be made in writing and sent to the department at Iowa Department of Public Health, Division of Acute Disease Prevention, Emergency Response and Environmental Health, 321 East 12th Street, Des Moines, Iowa 50319-0075. The complainant shall provide:

a. The name of the registered tester, the person or organization sponsoring an approved course, or the third-party certification agency, as applicable; and

b. The specific details of the action(s) by the registered tester that did not comply with the rules; or

c. The specific way(s) that an approved course did not comply with the rules, including the date(s) and location(s) of the alleged violation(s); or

d. The specific way(s) that a third-party certification agency or its representative failed to comply with the rules, including date(s) and location(s) of the alleged failure to comply.

26.8(5) Appeals.

a. Notice of denial, probation, suspension or revocation of registration; denial, probation or revocation of course approval; or denial, probation or revocation of third-party certification agency approval shall be sent to the affected individual or organization by restricted certified mail, return receipt requested, or by personal service. The affected individual or organization shall have a right to appeal the denial, probation, suspension or revocation.

b. An appeal of a denial, probation, suspension or revocation shall be submitted by certified mail, return receipt requested, within 30 days of receipt of the department's notice. The appeal shall be sent to Iowa Department of Public Health, Division of Acute Disease Prevention, Emergency Response and Environmental Health, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319-0075. If such a request is made within the 30-day time period, the notice of denial, probation, suspension or revocation 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 denial, probation, 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 denial, probation, suspension or revocation. If no appeal is

submitted within 30 days, the denial, probation, suspension or revocation shall become the department's final agency action.

c. Upon receipt of an appeal that meets contested case status, the appeal shall be transmitted to the department of inspections and appeals within five working days of receipt pursuant to the rules adopted by that agency regarding the transmission of contested cases. The information upon which the denial, suspension or revocation is based shall be provided to the department of inspections and appeals.

d. The hearing shall be conducted in accordance with 481—Chapter 10.

e. 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. The 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 as provided in paragraph 26.8(5)*"f."*

f. Any appeal to the director of the department 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 appeal shall state the reason for appeal.

g. 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:

(1) All pleadings, motions and rules.

(2) All evidence received or considered and all other submissions by recording or transcript.

(3) A statement of all matters officially noticed.

(4) All questions and offers of proof, objections, and rulings thereon.

(5) All proposed findings and exceptions.

(6) The proposed findings and order of the administrative law judge.

h. 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.

i. 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.

j. 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 by certified mail, return receipt requested, or by personal service to the department at Iowa Department of Public Health, Division of Acute Disease Prevention, Emergency Response and Environmental Health, 321 East 12th Street, Des Moines, Iowa 50319-0075.

k. 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.

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CHAPTER 43
MINIMUM REQUIREMENTS FOR RADON TESTING AND ANALYSIS

641—43.1(136B) Purpose and scope. This chapter establishes requirements for the certification of radon measurement specialists and radon measurement laboratories. All persons performing measurements for radon or radon progeny in buildings, other than those which they own or occupy, and who provide the results of these measurements to the owner or occupant of these structures must be certified in accordance with the provisions of this chapter.

641—43.2(136B) Definitions. The following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise.

"Act" means the Iowa Radon Testing Act (Iowa Code chapter 136B).

"Building" means a structure enclosed with exterior walls or fire walls, built, erected and framed of component structural parts, and designed for the housing, shelter, enclosure and support of individuals.

"Certified person" means a certified radon measurement specialist or certified radon measurement laboratory as defined by this chapter.

"Certified radon measurement laboratory (certified laboratory)" means a commercial laboratory which may analyze samples or test for radon decay products and meets the provisions for certification in this chapter.

"Certified radon measurement specialist (certified specialist)" means an individual who performs radon or radon progeny measurements in buildings and provides professional or expert advice on radon and radon progeny measurements, radon entry routes, and other radon-related activities; is knowledgeable in the health risk associated from exposure to radon; and who meets the provisions for certification in this chapter.

"Compensation" means any form of monetary gain which in any way directly or indirectly results from a radon or radon progeny measurement being conducted.

"Department" means the Iowa department of public health.

"EPA" means the United States Environmental Protection Agency.

"Laboratory" means any person performing analysis, not at a testing site, on a passive device to measure radon or radon progeny (charcoal canister, alpha-track, electret, etc.).

"NEHA" means the National Environmental Health Association.

"NRSB" means the National Radon Safety Board.

"Person" means an individual, corporation, partnership, firm, association, trust, estate, public or private institution, group, agency, any other state or political subdivision or agency, and a legal successor, representative, agency or agencies of the entities listed in this paragraph.

"Picocurie per liter" means a quantity of radioactive material per liter of air that will produce 2.2 disintegrations per minute of radiation. It may be used as a measure of the concentration of radon gas in air. One curie is equivalent to one trillion picocuries.

"Radon" means the radioactive noble gas radon-222.

"Radon progeny" means the short-lived radionuclides formed as a result of the decay of radon-222, including polonium-218, lead-214, bismuth-214, and polonium-214.

"Working level (WL)" means the concentration of radon progeny that will result in 130,000 million electron volts of alphaparticle energy released per liter of air. Working level is a measure of radon decay product concentration in air.

641—43.3(136B) General provisions.

43.3(1) Except as provided in this chapter, no person may test for the presence of radon or radon progeny in the state of Iowa unless the person has been certified by the department of public health. This requirement also applies to persons whose place of business is located in Iowa, or in a state other than Iowa, and who offer radon testing to residents of Iowa either directly, through the mail, or by other means.

43.3(2) Individual qualifications for radon measurement specialist. No individual may be certified as a radon measurement specialist unless all of the following conditions are met:

a. Be at least 18 years of age at the time of application;

b. Possess two years of relevant professional work experience. Relevant postsecondary education may be substituted for professional work experience. Relevant postsecondary education includes a college curriculum in architecture, engineering, building construction or the physical sciences. Relevant professional work experience includes house testing/evaluation for the presence of radon, design and installation of heating, ventilation and air-conditioning systems, design or construction of buildings, or related activities approved by the department of public health;

c. Use detection devices approved by EPA and the department to measure radon. The detection device must be obtained from an Iowa certified radon measurement laboratory. When a portable electronic detection device is used, the device must be calibrated on at least an annual basis by the manufacturer, or by persons acceptable to the department. The records of calibration must be maintained for review by the department or agents of the department.

43.3(3) Requirements for continued certification shall include the following:

a. A certified person located within the state of Iowa shall allow the department, its agents, employees, and contractors, upon presentation of appropriate credentials, to have access without undue delay to the person's facilities, offices and files for inspection and examination of records and equipment. The certified person shall also allow the department, its agents, employees, and contractors to accompany the person while performing any radon measurement, for the purpose of inspection of those activities, with the approval of the property owner or resident on whose property the activities are being performed.

b. The certified person shall remain in compliance with the Act and this chapter.

[**ARC 2838C**, IAB 12/7/16, effective 1/11/17]

641—43.4(136B) Application for certification.

43.4(1) An application for certification or renewal of certification as a radon measurement specialist or a radon measurement laboratory shall be filed on a form or other electronic document as prescribed by the department and shall contain complete and accurate information.

a. An application for a radon measurement specialist must include:

(1) Proof of successful completion of a department-approved training course on radon/radon progeny measurements. A certificate of attendance is required.

(2) Proof of successful completion of an examination approved by this department. A letter from NEHA or NRSB showing a passing score for the radon measurement specialist examination fulfills this requirement.

(3) Proof of two years of postsecondary education in architecture, natural science, engineering, or a related discipline. A college transcript must be included to fulfill this requirement or a detailed resume evidencing two years of relevant professional work experience, such as conducting professional home inspections; or the design and installation of heating, ventilation and air-conditioning systems; or the design or construction of buildings; or related activities approved by the department; or a combination of professional work experience and postsecondary education.

(4) A quality assurance/quality control (QA/QC) plan for all measurement devices and equipment. If laboratory devices are used, the names and addresses of the Iowa certified radon measurement laboratories must be included. If a continuous radon monitor is used, the name of the manufacturer, model, and picture of the monitor must be included. The manufacturer of any device used must have EPA or other national agency approval which indicates the device has been approved for measuring radon. Only measurement devices from Iowa certified radon measurement laboratories or a continuous radon monitor that has been satisfactorily calibrated and approved by the Iowa radon program are allowed for use in performing radon measurements.

(5) Standard operating procedures (SOPs). Procedures must include information concerning the placement and pickup of devices used, who performs the tests, and what measures will be used to ensure all tests are in conformance with EPA protocols and procedures.

(6) A signed statement that the individual will follow all EPA radon measurement guidelines and protocols.

(7) A signed statement that the individual will submit radon test results every 30 days to the Iowa radon program within the department. The radon test results shall be submitted in a manner that is approved by the department.

(8) A signed statement that the individual will keep all records for a minimum of five years after the radon test is completed.

(9) A copy of the confidentiality waiver that reports results to the customer as outlined in Iowa Code section 136B.2.

(10) A signed statement that the individual will submit to the department within 14 working days any changes in the original application and that the individual will acquire at least eight hours of continuing education credits every two years before certification is renewed.

(11) The fee specified in 43.4(6).

b. An application for a radon measurement laboratory must include:

(1) Proof of successful participation in the NEHA or NRSB Radon/Radon Progeny Measurement Proficiency Program.

(2) A quality assurance plan and quality control procedures for all measurements and equipment.

(3) A signed statement that all EPA, NEHA and NRSB and any department measurement guidelines and protocols will be followed.

(4) Name(s) and address(es) of any retail operation(s) selling the laboratory's testing service(s) within Iowa.

(5) A signed statement that all changes in the original application will be submitted to the department within 14 working days.

(6) The fee specified in 43.4(6).

43.4(2) The department may require the applicant to submit supplementary statements containing additional information to enable the department to determine whether an application should be approved or denied, or whether a previously issued certification should be amended, suspended, or revoked.

43.4(3) Each application or supplementary statement shall be signed by either the applicant personally, or a person authorized in writing by the applicant to do so on the applicant's behalf.

43.4(4) A certification will be valid for one year following the date of issuance. No radon measurement covered by this chapter can be conducted after the expiration of the term of certification unless an application for renewal certification has been received by the department 30 days prior to the expiration date of certification and is pending approval. If the application is rejected, no radon test or measurement may be conducted by that applicant in the state of Iowa if a financial arrangement is involved.

43.4(5) Renewal of an annual certification must contain all the information requested in the Notice of Renewal for certification along with the fee specified in subrule 43.4(6). The application to renew credentials must also include a signed and dated continuing education form and a copy of a course certificate which indicates the name of the individual receiving continuing education, the amount of continuing education the individual has received, and the date the continuing education course was given.

43.4(6) Radon certification fees. Any person wishing to become certified as a radon measurement specialist or as a radon measurement laboratory is required to pay fees sufficient to defray the cost of administering this chapter. Fees which must be submitted are as follows:

a. Application fee.

(1) Each person with Iowa residency wishing certification under the provisions of 641—43.1(136B) shall pay a nonrefundable $25 application fee.

(2) Each person without Iowa residency wishing certification under 641—43.1(136B) shall pay a nonrefundable $100 application fee.

b. Annual certification fee.

(1) Each individual requesting certification and renewing certification as a radon measurement specialist must pay a nonrefundable annual fee of $250.

(2) Each person requesting certification and renewing certification as a radon measurement laboratory must pay a nonrefundable annual fee of $500.

c. Each person wishing to give reciprocal recognition of credentials from another jurisdiction must pay the appropriate fees in 43.4(6).

d. Returned check and late fees. Persons who fail to pay required fees to the department are subject to the following penalty(ies):

(1) $15 for each insufficient funds check submitted for payment of radon testing fees.

(2) $25 per month for failure to pay annual radon testing certification fees starting after the annual renewal date or date of expiration.

e. If payment is not received and the certification has been expired 30 days, certification shall become inactive. In order to reinstate certification after 30 days past the expiration date, the person must reapply and pay the appropriate fees as outlined in this subrule.

[**ARC 2838C**, IAB 12/7/16, effective 1/11/17]

641—43.5(136B) Enforcement actions.

43.5(1) Rescinded ARC 2838C, IAB 12/7/16, effective 1/11/17.

43.5(2) The department may deny, suspend, revoke, modify the certification of a person, place on probation, impose a civil penalty, or refer the case to the office of the county attorney for possible criminal penalties pursuant to Iowa Code chapter 136B, or any combination thereof, when it finds that a certified person or a person who is not certified has committed any of the following:

a. Failing to submit required information or notifications in a timely manner;

b. Failing to maintain the required records;

c. Falsifying approval records, qualifications, or other information or documentation related to certification approval;

d. Failing to comply with the training standards and requirements in 43.3(2);

e. Submitting in the application for approval or reapproval false or misleading statements which the department relied upon in approving the application;

f. Failing to comply with federal, state, or local statutes and regulations, including the requirements of this chapter;

g. Knowingly making misleading, deceptive, untrue, or fraudulent representations involving radon, or engaging in unethical conduct or practice harmful or detrimental to the public. Proof of actual injury need not be established;

h. Using untruthful or improbable statements in advertisements. Use of these statements includes, but is not limited to, the presentation of information to the public by training programs that is false, deceptive, or misleading, or that is promoted through fraud or misrepresentation;

i. Falsifying reports and records required by this chapter;

j. Accepting any fee by fraud or misrepresentation;

k. Revocation, suspension, or other disciplinary action taken by a certification or licensing authority of this state, another state, territory, or country; or failure by the firm or individual to report such action in writing within 30 days of the final action by such certification or licensing authority. A stay by an appellate court shall not negate this requirement; however, if such disciplinary action is overturned or reversed by a court of last resort, the report shall be expunged from the records of the board;

l. Failing to comply with the terms of a department order or the terms of a settlement agreement or consent order;

m. Representation by a firm or individual that the firm or individual is certified when the certification has been suspended or revoked or has not been renewed;

n. Failing to respond within 30 days of receipt of communication from the department that was sent by registered or certified mail;

o. Engaging in any conduct that subverts or attempts to subvert a department investigation;

p. Failing to comply with a subpoena issued by the department or failing to cooperate with a department investigation;

q. Failing to pay costs assessed in any disciplinary action;

r. Any condition revealed by the application, supplementary statement, report, record, or other evidence, which would warrant the department's refusal to grant a certification on an original application;

s. Being discontinued or removed from the NEHA or NRSB Radon/Radon Progeny Measurement Proficiency Program; or

t. Failing to submit radon test data as required in 641—43.6(136B).

[**ARC 2838C**, IAB 12/7/16, effective 1/11/17]

641—43.6(136B) Reporting requirements.

43.6(1) A certified person must submit to the department within 30 days after any radon/radon progeny testing, or at the request of the department prior to testing, the address or location of the building, the name and telephone number of the owner(s) of the building where the radon testing will be conducted and the results of any tests performed.

43.6(2) The results for each test conducted shall include, but not necessarily be limited to:

a. The method used for radon or radon decay product testing, media tested, and conditions under which the testing was or will be performed.

b. The level or floor of building where the test(s) was or will be conducted.

c. The results of the test(s) in picocuries/liter (pCi/l) of radon gas or working level (WL) of radon decay products.

d. The date on which the test was or will be conducted.

e. The purpose of the test.

43.6(3) Rescinded IAB 5/29/91, effective 5/10/91.

43.6(4) A certified person shall:

a. Cooperate with the department when conducting field evaluations.

b. Notify the department within 14 days of any changes in testing results or procedures.

c. Not disclose to any other person, except to the department, the results of a test or the address or the name of the owner of a nonpublic building that the person tested for the presence of radon gas and radon progeny, unless the owner of the building waives, in writing, this right of confidentiality. However, a person certified or credentialed pursuant to Iowa Code section 136B.1 may disclose the results of a test performed by the person for the presence of radon and radon progeny to a potential buyer of a nonpublic building when an offer to purchase has been presented by the buyer and if the potential buyer paid for the testing. Any test results disclosed shall be results of a test performed within the five years prior to the date of the disclosure.

[**ARC 2838C**, IAB 12/7/16, effective 1/11/17]

641—43.7(136B) Training and continuing education programs. Each person conducting radon-related activities shall complete a radon measurement training program approved by the department. All certified individuals must participate in a continuing education program every other year that consists of a minimum of eight hours of department-approved courses or seminars on either radon measurement or mitigation or both.

641—43.8(136B) Exemptions. Certification requirements shall not apply to:

1. Those persons who test for radon/radon decay products in buildings that they own or who perform radon tests for no compensation.

2. State officials who are conducting radon testing as part of the state's radon testing program or local officials who are acting on behalf of the state or administering a local program, and approved by the department.

3. Officials who are conducting radon testing as part of government programs in the United States or contractors working for the United States government.

[**ARC 2838C**, IAB 12/7/16, effective 1/11/17]

641—43.9(136B) Enforcement.

43.9(1) A certified individual who measures for radon or radon progeny in the state of Iowa must meet the requirements of this chapter.

43.9(2) Any laboratory providing analysis services for radon detectors used in Iowa must meet the provisions of this chapter.

43.9(3) Any certified individual is prohibited from using radon measurement devices in Iowa obtained from a laboratory which is not certified under the provisions of this chapter.

641—43.10(136B) Penalties. It is unlawful for an individual to function as a radon measurement specialist or radon measurement laboratory in violation of the provisions of the Iowa radon testing Act or of any rule adopted pursuant to the Act. In addition to other sanctions provided in this chapter, persons convicted of violating the provisions of the Act or the rules adopted pursuant to the Act shall be guilty of a serious misdemeanor (Iowa Code section 136B.5).
[**ARC 2838C**, IAB 12/7/16, effective 1/11/17]

641—43.11(136B) Persons exempted from certification. Persons providing radon or radon progeny measurement devices to the public, but not conducting physical tests for the presence of radon or radon progeny with the measurement devices may do so under the following conditions:

1. They must provide measurement devices obtained from a laboratory certified in Iowa.
2. A valid visible expiration date must be permanently affixed to each measurement device.
3. In addition to the required laboratory instructions regarding measurement procedures, each measurement device must be accompanied by clear directions on where to obtain additional information and interpretation for test results. The certified laboratory or a certified specialist must be included as one of the sources of information and interpretation.

These rules are intended to implement Iowa Code chapter 136B.

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CHAPTER 73
SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)

[Prior to 7/29/87, Health Department[470] Ch 73]

641—73.1(135) Program explanation. The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a federal program operated pursuant to agreement with the states. The purpose of the program is to provide supplemental foods and nutrition education to eligible pregnant, postpartum, and breastfeeding women, infants, and young children from families with inadequate incomes. The WIC program is administered on the federal level by the U.S. Department of Agriculture, Food and Nutrition Service (FNS). The Iowa department of public health serves as the administering agency for the state of Iowa. The Iowa department of public health enters into contracts with selected local agencies on an annual basis for the provision of WIC services to eligible participants.

641—73.2(135) Adoption by reference. Federal regulations in 7 CFR Part 246 found at http://www.fns.usda.gov/sites/default/files/wic/WICRegulations-7CFR246.pdf (effective as of February 13, 1985, as amended through January 1, 2016, and any additional amendments), WIC EBT operating rules found at http://www.fns.usda.gov/sites/default/files/wic/WIC-EBT-Operating-Rules-September-2014.pdf (effective as of November 2009, as amended through September 2014, and any additional amendments), the WIC EBT technical implementation guide found at http://www.fns.usda.gov/sites/default/files/WICEBT-TechnicalImplementationGuide.pdf (as amended through September 30, 2012, and any additional amendments), FNS Handbook 901 found at http://www.fns.usda.gov/sites/default/files/2015-08-26-FNS_Handbook%20901-v1-8-1.pdf (as amended through May 28, 2015, and any additional amendments), and FNS Instruction 113-1 found at http://www.fns.usda.gov/sites/default/files/113-1.pdf (effective as of November 8, 2005, and any additional amendments) shall be the authority for rules governing the Iowa WIC program and are incorporated by reference herein. The Iowa WIC Policy and Procedure Manual, which provides procedural guidance in the implementation of these regulations to contract agencies administering the WIC programs and which contains policies and procedures as approved by the United States Department of Agriculture, is incorporated herein by reference.

[**ARC 2839C**, IAB 12/7/16, effective 1/11/17]

641—73.3(135) Availability of rules and policy and procedure manual. Copies of the federal rules and the Iowa WIC Policy and Procedure Manual adopted by reference in 641—73.2(135) are available from: Chief, Bureau of Nutrition and Health Promotion, Iowa Department of Public Health, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319-0075; (515)281-7095 or 1-800-532-1579.

[**ARC 2839C**, IAB 12/7/16, effective 1/11/17]

641—73.4(135) Definitions.

"Above-50-percent vendor" means a vendor that derives more than 50 percent of the vendor's annual food sales revenue from WIC food instruments, and a new vendor applicant expected to meet this criterion under guidelines approved by FNS.

"Applicant" means a pregnant woman, breastfeeding woman, postpartum woman, an infant or a child who is applying to receive WIC benefits and the breastfed infant(s) of an applicant breastfeeding woman. "Applicant" includes an individual who is currently participating in the program and who is reapplying because the individual's certification period is about to expire.

"Authorized supplemental food" means supplemental food authorized by the state or local agency for issuance to a participant.

"Breastfeeding" means the practice of feeding a mother's breast milk to her infant(s) on the average of at least once a day.

"Breastfeeding woman" means a woman up to one year postpartum who is breastfeeding her infant(s).

"Cash-value benefit" means a fixed-dollar amount food instrument which is used by a participant to obtain authorized fruits and vegetables.

"Categorical eligibility" means a person who meets the definition of a pregnant woman, breastfeeding woman, postpartum woman, or infant or child.

"Certification" means the implementation of criteria and procedures to assess and document each applicant's eligibility for the program.

"Chief state health officer" or *"director"* means the director of the Iowa department of public health.

"Child" means a person who has had his or her first birthday but has not yet attained his or her fifth birthday.

"Clinic" means a facility where applicants are certified.

"Competent professional authority" or *"CPA"* means an individual on the staff of the contract agency who, using standardized WIC screening tools and eligibility criteria provided by the department, determines whether an applicant for WIC services is eligible to receive those services. A CPA shall be a member of one of the following categories:

1. A dietitian licensed by the Iowa board of dietetics;
2. A nutrition educator as defined in the Iowa WIC Policy and Procedure Manual;
3. A physician, registered nurse or licensed physician assistant.

"Compliance buy" means a covert, on-site investigation in which a representative of the WIC program poses as a participant, parent or caretaker of an infant or child participant, or proxy, transacts one or more food instruments or cash-value benefits, and does not reveal during the visit that he or she is a program representative.

"Contract agency" means a private, nonprofit or public agency that has a contract with the department to provide WIC services and receives funds from the department for that purpose.

"Department" means the Iowa department of public health.

"Disqualification" means the act of ending the WIC program participation of a participant, authorized food vendor, or authorized state or local agency, whether as a punitive sanction or for administrative reasons.

"Division director" means the director of the division of health promotion and chronic disease prevention, Iowa department of public health.

"ECR" means electronic cash register.

"eWIC" means functions related to the electronic benefits transfer (EBT) card.

"Family" means a group of related or nonrelated individuals who are living together as one economic unit, except that residents of a homeless facility or an institution shall not all be considered as members of a single family.

"Fiscal year" means the period of 12 calendar months beginning October 1 of any calendar year and ending September 30 of the following calendar year.

"FNS" means the Food and Nutrition Service of the U.S. Department of Agriculture.

"Food instrument" means a voucher, check, coupon, electronic benefits transfer (EBT-eWIC) card or any other document used to obtain supplemental foods.

"Health professional" means an individual who is licensed to provide health care or social services within the individual's scope of practice.

"Health services" means ongoing, routine pediatric and obstetric care (such as infant and child care and prenatal and postpartum examinations) or referral for treatment.

"Hearing officer" means the contract agency director, health professional, community leader or impartial citizen who is designated to hear the appeal of a participant, and is not to be confused with the statutory definition of a hearing officer, which is an administrative law judge.

"Homeless facility" means the following types of facilities which provide meal service: a supervised publicly or privately operated shelter (including a welfare hotel or congregate shelter) designed to provide temporary living accommodations; a facility that provides a temporary residence for individuals intended

to be institutionalized; or a public or private place not designed for, or normally used as, a regular sleeping accommodation for human beings.

"Homeless participant" means a woman, infant or child:

1. Who lacks a fixed and regular nighttime residence; or
2. Whose primary nighttime residence is:

- A supervised publicly or privately operated shelter (including a welfare hotel, a congregate shelter, or a shelter for victims of domestic violence) designated to provide temporary living accommodations;
- An institution that provides a temporary residence for individuals intended to be institutionalized;
- A temporary accommodation of not more than 365 days in the residence of another individual; or
- A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

"Infant formula" means a food that meets the definition of an infant formula in Section 201(z) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(z)) and that meets the requirements for an infant formula under Section 412 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 350a) and the regulations at 21 CFR Parts 106 and 107.

"Infant" means a person under one year of age.

"Iowa WIC Policy and Procedure Manual" means all of the state WIC policies and procedures that describe the manner in which the department implements and operates all aspects of program administration within its jurisdiction in accordance with 7 CFR Part 246.

"Nutritional risk" means:

1. Detrimental or abnormal nutritional conditions detectable by biochemical or anthropometric measurements;
2. Other documented nutritionally related medical conditions;
3. Dietary deficiencies that impair or endanger health;
4. Conditions that directly affect the nutritional health of a person, including alcoholism or drug abuse; or
5. Conditions that predispose persons to inadequate nutritional patterns or nutritionally related medical conditions, including, but not limited to, homelessness and migrancy.

"Nutrition education" means an individual or group education session and the provision of information and educational materials designed to improve health status, achieve positive change in dietary and physical activity habits, and emphasize relationships between nutrition and health, all in keeping with the individual's personal, cultural, and socioeconomic preferences.

"Participant" means a pregnant woman, breastfeeding woman, postpartum woman, infant or child who is receiving supplemental foods under the program, and the breastfed infant(s) of a participant breastfeeding woman.

"Peer group" means a system of grouping WIC vendors according to structure; type; number of cash registers; square footage; and sales. Peer groups are used to establish statistical norms that an individual vendor may be compared against and provide the numeric baselines for the process of determining what may be fraudulent behavior.

"PIN" means personal identification number.

"Postpartum woman" means a woman up to six months postpregnancy who is not breastfeeding.

"Pregnant woman" means a woman determined to have one or more embryos or fetuses in utero.

"Rebate" means the amount of money refunded under cost containment procedures to the department from the manufacturer of the particular food product as the result of the purchase of the supplemental food with a voucher or other purchase instrument by a participant in the department's WIC program. Such rebates shall be payments made subsequent to the exchange of a food instrument for food.

"Routine monitoring" means overt, on-site monitoring during which WIC program representatives identify themselves to vendor personnel.

"SNAP" or *"Supplemental Nutrition Assistance Program,"* formerly known as the Food Stamp Program, means the program authorized by the Food and Nutrition Act of 2008 (7 U.S.C. 2011, et seq.), in which eligible households receive benefits that can be used to purchase food items from authorized retail vendors and farmers' markets.

"USDA" means the United States Department of Agriculture.

"Vendor" means a retail outlet that provides supplemental food to WIC program participants.

"Vendor authorization" means the process by which the department assesses, selects, and enters into agreements with vendors that apply or subsequently reapply to be authorized as vendors.

"Vendor overcharge" means intentionally charging the department more for authorized supplemental foods than is permitted under the vendor agreement. It is not a vendor overcharge when a vendor submits a food instrument for redemption and the department makes a price adjustment to the food instrument.

"Vendor violation" means any intentional or unintentional action of a vendor's current owners, officers, managers, agents, or employees (with or without the knowledge of management) that violates the vendor agreement or federal or state statutes, regulations, policies, or procedures governing the WIC program.

"WIC program" means the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) authorized by Section 17 of the Child Nutrition Act of 1966.

"WIC Vendor Instructions and Agreement Booklet" means the grocery vendor application, grocery vendor application guidance, special purpose vendor application, special purpose vendor application guidance, and vendor agreement.

[**ARC 2839C**, IAB 12/7/16, effective 1/11/17]

641—73.5(135) Staffing of contract agencies.

73.5(1) The competent professional authority (CPA) shall conduct either the diet history or the health history part of the certification process or both histories and shall attest to the applicant's eligibility for services after the certification process is completed.

73.5(2) Contract agencies shall maintain on file documentation of qualifications for any individual employed or under contract as a CPA.

73.5(3) All contract agencies shall employ at least one licensed dietitian to provide services for participants determined to be at high risk. Nutrition educators employed by a contract agency shall be supervised by a licensed dietitian.

73.5(4) Proposed staffing patterns within contract agencies shall be subject to approval from the department following review in accord with established statewide WIC staff patterns.

[**ARC 2839C**, IAB 12/7/16, effective 1/11/17]

641—73.6(135) Certification of participants. The certification process to determine eligibility for WIC services, as defined in 7 CFR 246.7, shall include the following procedures and definitions:

73.6(1) *Application.* Information on identity, address, family incomes, and nutritional risk must be collected in accordance with the Iowa WIC Policy and Procedure Manual.

73.6(2) *Income.*

a. The income guidelines used shall be the same as the National School Lunch Program guidelines for reduced price school lunches, which are equal to 185 percent of the current federal poverty guidelines. Definitions of income are mandated by federal regulation and are described in the Iowa WIC Policy and Procedure Manual. Revised dollar figures for the 185 percent poverty level are published annually in the Federal Register and become effective for WIC no later than July 1 following their publication. Copies of the income definitions and monetary guidelines are available from the department.

b. Applicants must provide the contract agency written proof of their income as part of each certification process, pursuant to the Iowa WIC Policy and Procedure Manual.

73.6(3) *Time frame for services.*

a. The date of initial visit shall be the day on which an applicant first requests services from a contract agency. A visit to another program office to complete a common application form does not constitute an initial visit.

b. Pregnant women shall be certified for the duration of their pregnancy and for up to six weeks postpartum. Pregnant women precertified with referral data require a full certification within 30 days.

c. Priority II infants precertified with referral data require a full certification within 30 days of the infant's birth.

73.6(4) *Medical equipment.*

a. Medical equipment used in conducting WIC clinics shall be subject to approval by the department.

b. Standards for conducting the medical and nutritional assessments on WIC program applicants shall be as described in the Iowa WIC Policy and Procedure Manual.

c. Medical equipment shall be recalibrated in accord with procedures outlined in the Iowa WIC Policy and Procedure Manual.

73.6(5) *Documentation of health and nutrition information.* Documentation of health and nutrition information in individual participant records shall be as described in the Iowa WIC Policy and Procedure Manual.

73.6(6) *Documentation of nonmedical information.* Documentation of nonmedical information in individual participant and collective program records shall be as described in the Iowa WIC Policy and Procedure Manual.

73.6(7) *Transfer of participant information.* Requirements for use and disclosure of confidential applicant and participant information for non-WIC purposes were revised in the Federal Register September 27, 2006, Department of Agriculture, Food and Nutrition Service, 7 CFR Part 246, Miscellaneous Provisions; Final Rule 246.25(a)(4).

a. Designation by chief state health officer. The chief state health officer must designate in writing the permitted non-WIC uses of the information and the names of the organizations to which such information may be disclosed.

b. Notice to applicants and participants. The applicant or participant will be notified at the time of application (in accordance with 7 CFR 246.7(i)(11)) or through a subsequent notice that the chief state health officer may authorize the use and disclosure of information about an applicant's or participant's participation in the WIC program for non-WIC purposes. This statement will also indicate that such information will be used by state and local WIC agencies and public organizations only in the administration of programs that serve persons eligible for the WIC program.

c. Written agreement and policy and procedure manual. The state or local agency disclosing the information will enter into a written agreement with the other public organization or, in the case of a non-WIC use by a state or local WIC agency, the unit of the state or local agency that will be using the information. The department will also include in the Iowa WIC Policy and Procedure Manual, as specified in 7 CFR 246.4(a)(24), a list of all organizations (including units of the department or local agencies) with which the department or its local agencies have executed or intend to execute a written agreement. The written agreement must:

(1) Specify that the receiving organization may use the confidential applicant and participant information only for:

1. Establishing the eligibility of WIC applicants or participants for the programs that the organization administers;

2. Conducting outreach to WIC applicants and participants for such programs;

3. Enhancing the health, education, or well-being of WIC applicants or participants who are currently enrolled in such programs, including the reporting of known or suspected child abuse or neglect that is not otherwise required by state law;

4. Streamlining administrative procedures in order to minimize burdens on staff, applicants, or participants in either the receiving program or the WIC program; or

5. Assessing and evaluating the responsiveness of a state's health system to participants' health care needs and health care outcomes; and

(2) Contain the receiving organization's assurance that the organization will not use the information for any other purpose or disclose the information to a third party.

[**ARC 2839C**, IAB 12/7/16, effective 1/11/17]

641—73.7(135) Food delivery. Food delivery refers to all aspects of the method by which WIC participants receive food benefits, including but not limited to the issuing, distribution, and processing of personal food instruments redeemable through retail food markets and the statewide banking system. Food delivery shall be uniform throughout the state as provided for by these rules.

73.7(1) *Responsibilities of WIC participants.*

a. Prompt redemption of food instruments. A WIC participant must redeem WIC benefits within the validated date of use.

b. Claiming food instruments and benefits. Enrolled participants are required to appear in person to claim food instruments and benefits when they have appointments to certify or have nutrition education contacts. Missed attendance may entitle contract agencies to deny that month's benefit. A proxy may pick up food instruments as described in the Iowa WIC Policy and Procedure Manual.

c. Adherence to standards for use of the food instrument. The WIC participant in using the WIC food instrument to obtain the specified foods shall:

(1) At the time of receipt of food benefits in the clinic, electronically sign that food benefits were received.

(2) Swipe the eWIC card at the vendor's ECR and enter the participant's PIN at point of purchase.

(3) Not accept money in exchange for unused food benefits or portions of the food allotment.

(4) Attempt to redeem food benefits only with a WIC-contracted vendor.

73.7(2) *Responsibilities of contract agencies.*

a. Loss or theft of food instruments. The contract agency is responsible for any financial loss due to theft or other loss of food instruments from clinics. Steps for minimizing the chances of theft or loss are followed in accord with the Iowa WIC Policy and Procedure Manual.

b. Mailing of WIC food instruments. Mailing of food instruments to participants is allowed only in specific situations as described in the Iowa WIC Policy and Procedure Manual. Any mailing of WIC food instruments on a clinicwide basis must have prior approval from the state.

c. Training/monitoring of WIC vendors. The contract agency shall communicate information regarding the Iowa WIC program to vendors, as instructed by the department. Monitoring and training of vendors and securement of contracts shall be carried out in accordance with department directives outlined in the Iowa WIC Policy and Procedure Manual.

d. Food instrument/benefits distribution on non-clinic days. It is the policy of the Iowa WIC program to ensure maximum accessibility to program benefits by establishing alternate procedures for distributing WIC food instruments to participants on days other than regularly scheduled clinic days when the participant notified the contract agency on or before the clinic day of the participant's inability to appear at the clinic. Each contract agency shall establish written guidelines for assessing the adequacy of reasons presented for inability to appear and shall establish written procedures for alternative means of food instrument/benefits distribution when a participant timely presents adequate reasons for inability to appear on a regularly scheduled clinic day. These written guidelines and procedures shall be subject to review and approval by the department.

73.7(3) *Responsibilities of department.* Provision of foods through retail grocers and special purpose vendors is an integral part of the WIC program's function. It is the responsibility of the department to ensure that there are a sufficient number of vendors authorized to provide reasonable access for WIC participants. The department also has an obligation to ensure that both food and administrative funds are expended in the most efficient manner possible. As with all other purchases made by state government, this means that all vendors must meet minimum criteria for approval. The Iowa WIC program does not limit the number of vendors that may participate in the agency service area. A retailer that intends to derive more than 50 percent of annual revenue of the sale of food items from the redemption of WIC food instruments will not be allowed. The department shall be responsible for the following:

a. Approving or denying vendor applications. The department shall determine if applications meet the mandatory specifications in 73.7(4) and meet the minimum review points in 73.7(4) for a subsequent agreement.

b. Compiling the statewide or local area composite data against which vendor applications are reviewed, determining if applications meet the selection criteria which require use of that data, providing training, and signing the initial authorization agreement if a vendor is determined eligible.

c. Developing procedures, forms, and standards for agencies to use in conducting on-site review of vendor applications, monitoring, compliance buys, educational buy monitoring, or compliance investigations as defined in 73.7(5).

d. Determining when compliance investigation activities are necessary to verify WIC program violations, developing or approving standards and procedures to be used in conducting the activities, and arranging for an appropriate state or private agency to conduct the compliance buying investigation as required.

e. Providing to vendors written notice of WIC program violations and sanctions.

f. Ensuring that activities related to eWIC follow information provided by FNS's WIC EBT operating rules, WIC EBT Technical Implementation Guide and FNS Handbook 901.

73.7(4) *Responsibilities of WIC vendors.* A potential vendor shall make application to the Iowa department of public health WIC program and shall accept the obligations imposed by the signing of a WIC vendor agreement prior to acceptance of any WIC food instrument. The two categories for which any potential vendor may apply are grocery vendors and special purpose vendors. A retailer that intends to derive more than 50 percent of annual revenue of the sale of food items, for grocery vendors, or of infant and special medical formula, for special purpose vendors, from the redemption of WIC food instruments will not be approved.

a. Grocery vendor agreement. To qualify for a grocery vendor agreement with the Iowa WIC program, a retail outlet shall meet all of the following criteria:

(1) The vendor must stock all of the following categories of items to be defined as a grocery vendor: a minimum of 5 linear feet of raw fruits and vegetables; a minimum of 12 linear feet of unbreaded fresh or frozen meats and poultry (prepackaged luncheon meats do not qualify); canned and frozen vegetables; dairy products; cereals; and breads.

(2) No more than 20 percent of the vendor's gross retail sales may be from the sale of gasoline or other automotive supplies.

(3) No more than 20 percent of the vendor's gross retail sales may be from the sale of alcoholic beverages and tobacco products.

(4) The vendor must maintain regular business hours. This shall include a minimum of two 4-hour blocks of time on each of five days per week. Daily operating hours shall be consistent from week to week and shall be posted.

(5) The vendor must stock the minimum variety and quantity of WIC-approved foods as defined in the latest revised version of the Iowa WIC vendor application.

1. The specific brands of products that are included on the WIC-approved food list shall be made available to the vendor at the time of application and prior to renewal of each agreement.

2. The variety and quantity in stock are defined as including both inventory on display and in on-premises storage, but not inventory on order from suppliers.

(6) The vendor must purchase formula only from state-licensed wholesalers, distributors, retailers, and infant formula manufacturers registered with the Food and Drug Administration (FDA) through a list maintained by the WIC program.

(7) A vendor shall charge a price to WIC participants that is equal to or less than the price charged to all other customers. The prices charged to WIC participants for the average of all WIC items, as reported on the application, at the time of the on-site review, and throughout the agreement period, shall not exceed 105 percent of the average prices of all other WIC vendors in the same peer group. The vendor's average price for any category of WIC items, as reported on the application, at the time of the on-site review, and throughout the agreement period, shall not exceed 115 percent of the average price charged for the same category by all other WIC vendors in the same peer group. Categories refer to the broad groupings of items rather than specific brands. For purposes of making the price comparisons, the average price for all other WIC vendors in the peer group shall be computed from the most recent Price Assessment Reports on file from those vendors. If a vendor intends to comply with this provision by

charging WIC participants a lower price than the price charged to other customers, the WIC price for each approved item must be identified on the package or shelf front.

(8) Vendors will also be selected based on access to WIC participants. If at all possible, at least one vendor contract will be maintained in rural counties where a WIC clinic is located. The Iowa WIC program does not limit the number of vendors that may participate in the agency service area.

(9) The vendor must have a current state of Iowa food establishment license.

(10) The vendor must consistently identify WIC products by using shelf labels that meet specific criteria and price points as described in the WIC Vendor Instructions and Agreement Booklet as found in the Iowa WIC Policy and Procedure Manual.

(11) The vendor must not have had a Supplemental Nutrition Assistance Program (SNAP) disqualification or civil monetary penalty imposed within the 12 months preceding the date of the application or reauthorization.

(12) The vendor must not have had a WIC program suspension imposed or a WIC application denied within the six-month period preceding the date of the application.

(13) The vendor must not have had a conviction or civil judgment for any activity that indicates a lack of business integrity against any of the officers or owners during the previous six years.

(14) The vendor must accept training on WIC program regulations prior to signing an agreement and must agree to provide training to all employees who will handle WIC food instruments prior to accepting any food instruments.

(15) The vendor must agree to adhere to all provisions of the WIC Vendor Instructions and Agreement Booklet as found in the Iowa WIC Policy and Procedure Manual.

b. Special purpose vendor. To qualify as a special purpose vendor, a retail outlet shall meet all of the following criteria:

(1) The vendor may be primarily a retailer of any type of merchandise but shall be authorized to provide only specified infant formula in exchange for WIC food instruments.

(2) The vendor must be able to provide the specified formula within 48 hours; 72 hours if a weekend or holiday is involved.

(3) The prices charged to WIC participants must be equal to or less than the prices charged to all other customers. The average price of each brand of infant formula sold to WIC participants as reported must not exceed the average price of the same brands of infant formula charged by all authorized WIC grocery vendors in the same peer group.

(4) The vendor shall meet the criteria in paragraph 73.7(4)*"a,"* subparagraphs (2) through (4), (6) through (8), and (10) through (15), for grocery vendors.

(5) The vendor must agree to adhere to applicable provisions of the WIC Vendor Instructions and Agreement Booklet as found in the Iowa WIC Policy and Procedure Manual.

c. Application review. The department shall review each vendor application within five working days of receipt and determine if the information provided indicates that the retail outlet meets the selection criteria. If the application shows that the vendor does not meet one or more of the criteria, the department shall deny the application. If the vendor's application indicates that the vendor would qualify, the department or contract agency shall make an on-site visit to verify that the information provided in the application is correct, to provide training, and sign the agreement. If the department or contract agency finds that the vendor has two or more types of out-of-date, stale, or moldy WIC foods in stock during the on-site visit, the vendor's application may be denied. If the contract agency or department determines during the on-site visit that the vendor does not qualify, the contract agency or department shall not sign the agreement. Within five working days of disapproving an application or agreement, the department will advise the vendor in writing of the reasons for denial of the application and the procedure for appeal. During the on-site visit, the contract agency representative is acting as an agent of the department and has the authority to approve or deny an application.

A vendor that is denied an agreement, either at the application review level or at the on-site review, is required to wait six months prior to submitting a new application. Prior to completing its review, the department may, at its discretion, request a vendor to resubmit an application if the application has not been completed to the extent that a determination of eligibility can be made.

d. Reauthorization. If ownership of an authorized vendor changes during the agreement period, the agreement becomes void. The new owner must file an application and be approved prior to accepting WIC food instruments. Vendor agreements are valid only for the period of time specified, and a vendor may not continue accepting food instruments past the expiration date unless a new agreement is signed. When a currently authorized vendor makes application for a subsequent agreement, an agreement shall be signed only if the vendor has been assessed less than 60 violation points under paragraph 73.19(2)*"b"* during a contract period.

Vendors must complete a new application and sign a new WIC vendor agreement at least every three years to continue accepting WIC food instruments.

The department shall send the vendor written notice at least 30 days prior to the expiration of the agreement that it does not intend to offer the vendor a new agreement if the vendor has been assessed 60 or more violation points under paragraph 73.19(2)*"b"* during a contract period or if any of the following conditions are in effect:

(1) The vendor has failed to submit any of the preceding year's Price Assessment Reports by the specified dates.

(2) Any of the selection criteria listed in 73.7(4)*"a"* and *"b"* above are no longer met.

Expiration of a WIC agreement is not subject to appeal. A vendor who is not offered a new agreement by the department has the right to file a new application. If that application is denied, the vendor has the right to appeal.

e. Training. Vendors shall accept training in WIC program policies and procedures at the on-site review prior to becoming an authorized vendor and shall be responsible for training all employees who will be handling WIC food instruments. The manager and person responsible for staff training must allow time at this visit for training; the agreement will not be signed until training is completed. Vendors shall be responsible for all actions of their employees in conducting WIC transactions.

If violations of WIC program policies and procedures are documented, either through on-site monitoring or other indirect means, the vendor shall implement a corrective action training plan developed jointly by the vendor and the department or contract agency.

f. Cooperation during monitorings. Contracted WIC vendors shall cooperate with department and contract agency staff who are present on site to monitor the vendor's WIC activities.

g. Reimbursement to the WIC program. Vendors determined by the department to have collected more moneys than the true value of food items received shall make reimbursement to the department.

73.7(5) *Vendor monitoring.* To maintain WIC program integrity and accountability for federal or state program funds, the department and contract agencies shall conduct ongoing monitoring of authorized vendors, both through on-site visits and through indirect means. A sample of 10 percent of currently authorized vendors receives on-site monitoring every year. Vendors that change ownership during the year or that apply during the contract period receive an on-site visit prior to signing an agreement. The types of on-site monitoring are defined as follows:

a. Routine or representative monitoring is used for vendors for which there is no record of violations or complaints or other indication of problems. It may include any or all of the following: use of a food instrument or observation of a participant, educational buys, review of inventory levels, review of vendor policies on return items, and review of employee training procedures. The results of the monitoring are reviewed with the owner or manager on duty, and a follow-up letter confirming the findings is sent from the department. Routine monitoring may be performed by the department or by contract agency staff under the direction of the department. Depending on the nature and severity of violations noted, the department may schedule additional visits, initiate a compliance investigation, or apply sanctions.

Educational buy monitoring is a specialized type of routine monitoring. Department or contract agency staff attempt to use a WIC food instrument to purchase unauthorized types or brands of foods to test the level of training of vendor employees. At the conclusion of the transaction, the results of the buy are discussed with the vendor owner or manager on duty. The transaction is then voided, and the merchandise returned to the shelves. Educational buys are used on authorized vendors selected by the department. If unauthorized items are allowed to be purchased, the vendor shall agree to a corrective

action training plan. A follow-up educational buy is scheduled within 30 to 90 days. A letter is sent from the department documenting the violation. By signing a WIC agreement, a vendor gives consent for educational buys by the department or contract agency. Vendors are not notified in advance that an educational buy is scheduled. The protocol for educational buys, including procedures, appropriate items to purchase, and forms to be used, is specified in the Iowa WIC Policy and Procedure Manual.

b. Electronic monitoring is examination of indicators tracked in the vendor computer database. It allows the analysis of data collected via computer from the contract agencies and the state's bank, from which patterns indicating compliance with or deviation from established patterns for Iowa WIC vendors emerge. Data is collected daily and reviewed on an ongoing basis. Trends identified can necessitate another type of monitoring, depending on the nature of each exception.

c. Compliance investigations may be used for any vendors. Compliance investigations will be conducted annually in a minimum percentage of vendors as mandated in federal regulations. A compliance investigation includes a sufficient number of compliance buys to provide evidence of WIC program noncompliance, two compliance buys in which no WIC program violations are found, or when an inventory audit has been completed. A compliance buy means a covert, on-site investigation in which a representative of the WIC program poses as a participant, parent or caretaker, or proxy, transacts one or more food instruments and does not reveal during the visit that he or she is a WIC representative. Compliance buys may be performed by the department or another state agency or private company under contract with the department. The department is responsible for identifying the vendors to be investigated and for approving the protocol to be used during the investigation. Upon completion of a compliance buy documenting WIC program violations, the department shall issue the vendor a notice of violation points assessed unless such notification would hinder an investigation.

The department also monitors vendor performance through in-office review of information. Such information, specifically the total amount of WIC redemptions, is confidential as provided for in Iowa Code section 22.7(6). This business information could provide an advantage to competitors and would serve no public purpose if made available.

[**ARC 2839C**, IAB 12/7/16, effective 1/11/17]

641—73.8(135) Food package. The authorized supplemental foods shall be prescribed for participants by a CPA in the contract agency from food packages outlined in 7 CFR 246.10 and in accordance with the following:

73.8(1) *Prescription of foods.* Food packages shall maintain a balance between cost and nutrition integrity. There are two components to this balance: (1) administrative adjustments by the department; and (2) nutrition tailoring by both the department and the CPA in the contract agencies.

a. Administrative adjustments include restrictions in the packaging methods, brands, sizes, types, and forms (but not quantities) of the federally allowable foods in order to establish the approved food list for the state. Administrative adjustments include decisions to eliminate more expensive brands or prohibit more costly food items allowed by regulations. Criteria for considering foods for inclusion in the approved food list are found in 73.8(3).

b. Nutrition tailoring includes changes or substitutions to food types, forms, and quantities in order to prescribe food packages that better meet the nutritional needs of participants. Tailoring is done to reduce quantities of foods based on nutritional needs, to accommodate participant preferences, to accommodate household conditions, such as lack of refrigeration or other special needs and problems of homeless or transient participants, and to recommend or prescribe specific forms of the allowable WIC foods based upon a participant's nutritional needs or goals.

73.8(2) *Tailoring to meet individual nutritional needs.* Food packages are individually tailored to meet the needs of specific participants according to USDA regulations and the Iowa WIC Policy and Procedure Manual.

73.8(3) *Criteria for approving products for inclusion in the WIC food package.*

a. A product shall meet the federal regulations governing the WIC food package.

b. Variety in the food package is encouraged to increase the likelihood of products being used and to allow participants to exercise responsibility in shopping.

c. Changes to the approved food list take effect on October 1 in years when new vendor contracts are signed. Inquiries from food companies about new and continuing products must be received prior to February 1 of the year vendor contracts expire to be guaranteed consideration. The state reserves the right to change the food list more frequently if necessary.

d. Cereals shall meet federal guidelines for content and shall also meet the following conditions:

(1) If a group of cereals from one manufacturer have similar names and package designs and some of the cereals do not qualify, the department reserves the right to not approve those types that would otherwise qualify, to reduce the potential for confusion by retail vendors and participants.

(2) The brand is carried by current Iowa WIC-approved vendors. Any private-label (store) brands that meet the selection criteria will also be considered.

(3) The department reserves the right to limit the number of approved cereals for administrative efficiency.

e. Juices shall meet the federal guidelines for vitamin C content and all of the following conditions:

(1) Juices are 100 percent juice and contain no added sugar, sweeteners or artificial sweeteners.

(2) The brand is carried by current Iowa WIC-approved vendors. Any private-label (store) brands that meet the selection criteria will also be considered.

(3) The product form and marketing approach are consistent with the promotion of good nutrition and education.

(4) If a group of juices from one manufacturer have similar names and package designs and some of the juices do not qualify, the department reserves the right to not approve those types that would otherwise qualify, to reduce the potential for confusion by retail vendors and participants. Single-strength and concentrated varieties of juice with the same brand name will be evaluated separately.

(5) Frozen fruit juices must be single flavors.

f. The following conditions apply to dairy products:

(1) To qualify, brands of whole, 1%, or fat-free skim milk marketed in Iowa must contain or be fortified with vitamins A and D to meet the federal standards. The department reserves the right to disqualify brands which have a retail value of 115 percent or higher than the state average for this product.

(2) Fluid milk with added bacterial cultures or enzymes, including but not limited to sweet acidophilus or lactose-reduced milk, may qualify. Brands are approved by the department on a case-by-case basis.

(3) All brands of natural cheese designated in the USDA WIC regulations qualify. The cheese shall have no added flavors (e.g., smoke flavoring, peppers, wine).

(4) Yogurt shall meet federal guidelines for content and shall also meet the following conditions:

1. The brand is carried by current Iowa WIC-approved vendors.

2. Nonfat, lowfat, and whole yogurts cannot contain artificial sweeteners. No frozen yogurt, yogurt tubes, or drinkable yogurts are allowed.

g. All brands of packaged dried beans or peas are approved; however, no soup mixes and no dried beans or peas with added vegetables, fruits, meat, sugars, fats, or oils are allowed.

h. Peanut butter must meet federal guidelines. Brands may be either refrigerated or nonrefrigerated.

i. Eggs shall be fresh, Grade A large chicken eggs. Eggs which have a retail value of 115 percent or higher than the state average for this product shall not be approved.

j. Any brand of tuna or salmon qualifies if it is either water- or oil-packed, in cans or pouches, chunked, solid, or flaked. Fish packaged with other items such as crackers, relish or other flavorings may not be purchased. Albacore tuna is not allowed.

k. Commercial infant formula shall meet the following conditions:

(1) It is registered with the Food and Drug Administration as complying with the legal definition of infant formula.

(2) It complies with the calorie and iron content prescribed by the USDA.

(3) It is approved by the USDA for use in the WIC program.

(4) The product form and marketing approach are consistent with the promotion of good nutrition and education.

l. At least two whole grain options that meet federal guidelines will be provided.

m. Infant food fruits, vegetables and meats must meet the federal guidelines.

n. Fresh and frozen vegetables and fruits that meet federal guidelines will be available for purchase with cash-value benefits specifically for fruits and vegetables.

o. Soy beverages shall meet federal guidelines.

p. Tofu shall meet federal guidelines.

q. Products will be evaluated for use in the Iowa WIC program based on nutrient content, packaging, container size, labeling, availability to wholesale distributors, cost and participant preference. The state reserves the right to limit the number of foods for the WIC-approved food list based on accessibility, availability, retail value of product, USDA recommendations, increased number of WIC participants, changes in appropriation of funds and administrative efficiency.

r. In addition to the criteria specified above, the department reserves the right to further restrict the number and types of brands of any products in order to contain the cost of the food package through competitive procurement of rebate contracts or other similar means.

s. The department reserves the right to discontinue specific brand names and products if the cost is 115 percent or higher than the state average for that particular product. The department reserves the right to add or delete products pursuant to federal regulations.

[**ARC 7984B**, IAB 7/29/09, effective 9/2/09; **ARC 2839C**, IAB 12/7/16, effective 1/11/17]

641—73.9(135) Education.

73.9(1) *Nutrition education for WIC participants.*

a. Nutrition education is provided as a benefit to all women and to parents of all children enrolled in the WIC program.

b. A minimum of two nutrition education contacts shall be offered to each woman participant or the parent/guardian of children/infants participating in WIC during each certification period.

c. Nutrition education shall be based on information obtained through the diet and health histories and shall be tailored to the specific nutrition need of the participant.

d. All pregnant women enrolled in WIC shall be offered education on the benefits of breastfeeding.

e. Education in normal nutrition, i.e., education in nutrition for life-cycle stages, shall be provided in accordance with the Iowa WIC Policy and Procedure Manual.

f. Participants who are at high risk, as defined in the Iowa WIC Policy and Procedure Manual, shall receive counseling and a nutrition plan of care developed by a licensed dietitian. The plan of care shall be documented in the participant record and shall include scheduling a minimum of one individual education contact by a licensed dietitian.

g. The department shall make nutrition education materials and resources available at no cost to contract agencies. The department reserves the right to review and approve or disapprove any printed materials or lesson plans developed by contract agencies.

h. To the extent that time and resources are available, nutrition education may be provided to applicants who are not eligible to receive other WIC services.

73.9(2) *Education of contract agency personnel.* Agencies accepting WIC funds shall be responsible for ensuring that all agency staff or contractors are adequately trained for their responsibilities. At a minimum, training shall include the components described in the Iowa WIC Policy and Procedure Manual.

Continuing education is an allowable WIC administrative expense for contract agency staff and contractors who provide nutrition education.

[**ARC 7984B**, IAB 7/29/09, effective 9/2/09; **ARC 2839C**, IAB 12/7/16, effective 1/11/17]

641—73.10(135) Health services. The WIC program shall serve in the arrangement of ongoing health services for its participants. Contract agencies not able to provide such health services directly shall enter into written agreements with other public health agency(ies) or private physician to ensure availability of health services.

73.10(1) *Written agreements.*

a. Contract for services. Contract agencies shall maintain an annual written, contractual agreement with any health agency performing WIC health assessments, whether for fee or exchange of service.

b. Memorandum of understanding. Contract agencies shall maintain a current memorandum of understanding with any health agency designated to provide ongoing health services to WIC participants and with any agency providing referral data.

73.10(2) *Referral procedures.* The contract agency shall be responsible for referral of WIC participants to appropriate health care providers, as determined by the WIC health professional's assessment of their condition.

a. Authorization for release of information. Except as indicated below, before releasing medical or other personal information, including name, to an outside agency, the contract agency shall secure the participant's or parent/legal guardian's written authorization to release such information. A statement shall be signed for each specific provider to which information is being sent. The information contained in individual participant records shall be confidential pursuant to 7 CFR 246.26.

Referrals to the department of human services' child protective services for investigation of potential child abuse may be made without obtaining a written release of information. Procedures for responding to a subpoena are made in accordance with the Iowa WIC Policy and Procedure Manual.

b. The referral form. A standard referral form, as provided by the department, shall be completed and sent to the referral agency. Documentation and follow-up are made in accord with the Iowa WIC Policy and Procedure Manual.

[**ARC 2839C**, IAB 12/7/16, effective 1/11/17]

641—73.11(135) Appeals and fair hearings—local agencies.

73.11(1) *Right of appeal.*

a. Applicant. An applicant may appeal the denial or rejection of a timely submitted application.

b. Contract agencies. The right to appeal shall be granted when, during the course of the contract or agreement period, a local agency is disqualified or any other action which affects participation is taken.

73.11(2) *Request for hearing.* The appeal shall be submitted in writing within ten business days of receipt of notification of the adverse decision. The appeal shall be addressed to the contract administrator cited in the competitive selection application guidance, Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075.

a. Applicant. In the event of an appeal, the department will continue working with the applicant awarded funding pending the outcome of the appeal.

b. Contract agencies. For participating contract agencies, a minimum of 60 days' advance notice will be given before the effective date of the action.

73.11(3) *Contested cases.* 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 (DIA) pursuant to the administrative rules adopted by DIA regarding the transmission of contested cases. The information upon which the adverse action is based and any additional information that may be provided by the aggrieved party shall also be provided to DIA.

73.11(4) *Notice of hearing.* Parties shall receive notice of the hearing in advance. The administrative law judge (ALJ) shall schedule the time, place, and date of the hearing so that the hearing is held as expeditiously as possible.

73.11(5) *Conduct of hearing.* The hearing shall be conducted according to the procedural rules of the department of inspections and appeals found in 481—Chapter 10, Iowa Administrative Code, and federal regulations found at 7 CFR 246.24. Copies of these regulations are available from the department of inspections and appeals upon request.

73.11(6) *Decision.* A written decision of the ALJ shall be issued, where possible, within 60 days from the date of the request for a hearing unless the parties agree to a longer period of time.

73.11(7) *Decision of ALJ.* When the ALJ makes a proposed decision and order, it shall be served by 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 filed by either of the parties as provided in 641—subrule 176.8(5) or the director serves notice on the parties of the director's intent to review the decision.

73.11(8) *Appeal to director.* Any appeal to the director for review of the proposed decision and order of the ALJ shall be filed in writing and mailed to the Director, Iowa Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075, by certified mail, return receipt requested, or delivered by personal service within ten days after the receipt of the ALJ's proposed decision and order by the aggrieved party. A copy of the appeal shall also be mailed to the ALJ. Any request for an appeal shall state the reason for appeal.

73.11(9) *Record of hearing.* Upon receipt of an appeal request, the ALJ 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 ALJ.

73.11(10) *Decision of director.* Upon receipt of a properly filed appeal, the director shall establish a briefing schedule and, at the discretion of the director, an opportunity for oral argument. An appeal to the director shall be based on the record made at the hearing. The director may reverse or modify any finding of fact if a preponderance of the evidence will support a determination to reverse or modify such a finding, or may reverse or modify any conclusion of law the director finds to be in error. The decision and order of the director shall be delivered by certified mail, return receipt requested, or by personal service, and becomes the department's final decision upon receipt by the aggrieved party.

73.11(11) *Exhausting administrative remedies.* 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 decision of the department who has exhausted all administrative remedies may petition for judicial review pursuant to Iowa Code chapter 17A.

73.11(12) *Petition for judicial review.* 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: Division Director, Division of Health Promotion and Chronic Disease Prevention, Iowa Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075. The party who appeals a final agency action to district court shall pay the costs of the preparation of a transcript of the contested case hearing for the district court.

[**ARC 2839C**, IAB 12/7/16, effective 1/11/17]

641—73.12(135) Right to appeal—participant.

73.12(1) *Right of appeal.* A WIC participant shall have the right to appeal whenever a decision or action of the department or contract agency results in the individual's denial of participation, disqualification, or termination from the WIC program. All hearings shall be conducted in accordance with these rules.

73.12(2) *Notification of appeal rights and right to hearing.* Each WIC program participant shall be notified in writing of the participant's right to appeal at the time of application and at the time of denial of eligibility or termination from the WIC program and at the time a participant receives a notice of a claim being established for repayment of improperly issued benefits. Appeal and hearing notices shall also be written, posted, and immediately available at contract agencies to explain the method by which a hearing is requested, and that the participant may present arguments at the hearing either personally or through a representative such as a relative, friend, legal counsel, or other spokesperson.

73.12(3) *Request for hearing.* A request for hearing by an individual or the individual's parent, guardian, or other representative must be made in writing or verbally. The request for hearing shall be

made to the contract agency within 90 days from the date the individual receives notice of the decision or action that is the subject of appeal.

73.12(4) *Receipt of benefits during appeal.* Participants who are involuntarily terminated from the WIC program prior to the end of the standard certification period shall continue to receive WIC program benefits while the decision to terminate is under administrative appeal, provided that subsequent certifications are completed as required. Participants who are terminated because of categorical ineligibility (e.g., a child over five years of age) shall not continue to receive benefits during the administrative appeal period. Participants who are terminated at the end of a certification period for failure to reapply, following notice of expiration of certification, shall not continue to receive benefits during the administrative appeal period. Applicants who are denied WIC program benefits at the initial certification or at subsequent recertifications, due to a finding of ineligibility, shall not receive benefits during the administrative appeal period.

73.12(5) *Hearing officer.* The hearing officer shall be impartial, shall not have been directly involved in the initial determination of the action being contested, and shall not have a personal stake in the decision. If the party filing the appeal objects prior to a scheduled hearing to a contract agency director serving as a hearing officer in a case involving the director's own agency, another hearing officer shall be selected and, if necessary, the hearing shall be rescheduled as expeditiously as possible. Contract agencies may seek the assistance of the state WIC office in the appointment of a hearing officer.

73.12(6) *Notice of hearing.* The hearing officer shall schedule the time, place and date of the hearing as expeditiously as possible. Parties shall receive notice of the hearing at least ten days in advance of the scheduled hearing. The hearing shall be accessible to the party requesting the hearing. The hearing shall be scheduled within three weeks from the date the contract agency received the request for a hearing, or as soon as possible thereafter, unless a later date is agreed upon by the parties.

73.12(7) *Conduct of hearing.* The hearing shall be conducted in accordance with federal regulations found at 7 CFR 246.23. Copies of these regulations are available from the contract agency and the department.

a. At a minimum, the party requesting the hearing or the party's representative shall have the opportunity to:

(1) Examine, prior to and during the hearing, the documents and records presented to support the decision under appeal;

(2) Be assisted or represented by an attorney or other person at the party's own expense;

(3) Bring witnesses;

(4) Question or refute any testimony or evidence, including an opportunity to confront and cross-examine adverse witnesses;

(5) Submit evidence to establish all pertinent facts and circumstances in the case;

(6) Advance arguments without undue interference.

b. If a participant fails to attend the hearing, the agency will reschedule the hearing and give the participant 20 days' notice. The participant may have another person as the participant's designee. If neither the participant nor the designee attends the second hearing, the appeal will be closed.

73.12(8) *Decision.* Decisions of the hearing officer shall be in writing and shall be based on evidence presented at the hearing. The decision shall summarize the facts of the case, specify the reasons for the decision, and identify the supporting evidence and pertinent regulations or policy. The decision shall be issued within 45 days of the receipt of the request for a hearing, unless a longer period is agreed upon by the parties.

73.12(9) *Appeal of decision to the department.* If either party to a hearing receives an unfavorable decision, that decision may be appealed to the department. Such appeals must be made within 15 days of the mailing date of the decision. Appeals shall be sent to the Division Director, Division of Health Promotion and Chronic Disease Prevention, Iowa Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075.

73.12(10) *Contested case.* Upon receipt of an appeal that meets contested case status, the appeal shall be forwarded within five working days to the Iowa department of inspections and appeals pursuant to the rules adopted by that agency regarding the transmission of contested cases. The information upon

which the adverse action is based and any additional information that may be provided by the aggrieved party shall also be provided to the Iowa department of inspections and appeals.

73.12(11) *Hearing.* Parties shall receive notice of the hearing in advance. The administrative law judge shall schedule the time, place and date of the hearing so that the hearing is held as expeditiously as possible. The hearing shall be conducted according to the procedural rules of the Iowa department of inspections and appeals found in 481—Chapter 10, Iowa Administrative Code.

73.12(12) *Decision of administrative law judge.* The administrative law judge's decision shall be issued within 60 days from the date of request for hearing. When the administrative law judge makes a proposed decision and order, it shall be served by certified mail, return receipt requested, or delivered by personal service. That proposed decision and order then becomes the department's final decision without further proceedings ten days after it is received by the aggrieved party unless an appeal to the director is taken as provided in subrule 73.12(13).

73.12(13) *Appeal to director.* 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, Iowa Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075, 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.

73.12(14) *Record of hearing.* 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.

73.12(15) *Decision of director.* An appeal to the director shall be based on the record of the hearing before the administrative law judge. The decision and order of the director becomes the department's final decision upon receipt by the aggrieved party and shall be delivered by certified mail, return receipt requested, or by personal service.

73.12(16) *Exhausting administrative remedies.* 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 decision of the department who has exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A.

73.12(17) *Petition for judicial review.* 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: Division Director, Division of Health Promotion and Chronic Disease Prevention, Iowa Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075.

73.12(18) *Benefits after decision.* If a final decision is in favor of the person requesting a hearing and benefits were denied or discontinued, benefits shall begin immediately and continue pending further review should an appeal to district court be filed. If a final decision is in favor of the contract agency, benefits shall be terminated, if still being received, as soon as administratively possible after the issuance of the decision. Benefits denied during an administrative appeal period may not be awarded retroactively following a final decision in favor of a person applying for benefits.

[**ARC 2839C**, IAB 12/7/16, effective 1/11/17]

641—73.13(135) Right to appeal—vendor.

73.13(1) *Right of appeal.* The right of appeal shall be granted when a vendor's application to participate is denied. The right to appeal shall also be granted when, during the course of the contract or agreement period, a vendor is disqualified or any other action which affects participation is taken. For

participating vendors, a minimum of 30 days' advance notice will be given before the effective date of the action. The right to appeal shall not be granted in the following circumstances:

a. When a vendor's contract expires.

b. When the department makes a determination regarding participant access.

c. When a vendor is disqualified from the WIC program as a result of a Supplemental Nutrition Assistance Program (SNAP) disqualification.

d. When there are disputes regarding food instrument or cash-value benefit payments and vendor claims (other than the opportunity to justify or correct a vendor overcharge or other error, as permitted by 7 CFR 246.12(k)(3)).

e. The denial of authorization, if the department vendor authorization is subject to the procurement procedures applicable to the department.

f. When a vendor does not agree with the validity or appropriateness of the department's vendor selection and limiting criteria, the department's peer group criteria, the department's above-50-percent vendor criteria, and the department's prohibition of incentive items and the department's denial of an above-50-percent vendor's request to provide an incentive item to customers pursuant to 7 CFR 246.12(h)(8).

g. Determination of the following by the department:

(1) Whether or not a vendor had an effective policy and program in effect to prevent trafficking and that the ownership of the vendor was not aware of, did not approve of, and was not involved in the conduct of the violation,

(2) To include or exclude an infant formula, manufacturer, wholesaler, distributor, or retailer from the approved-formula list required pursuant to 7 CFR 246.12(g)(11),

(3) Whether to notify a vendor in writing when an investigation reveals an initial violation to impose a sanction, pursuant to 7 CFR 246.12(l)(3).

73.13(2) *Request for hearing.* An appeal is brought by filing a written request for a hearing with the Division Director, Division of Health Promotion and Chronic Disease Prevention, Iowa Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075, within ten days of receipt of notification of the adverse action. The written request for hearing shall state the adverse action being appealed.

73.13(3) *Contested cases.* 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 pursuant to the rules adopted by that agency regarding the transmission of contested cases. The information upon which the adverse action is based and any additional information that may be provided by the aggrieved party shall also be provided to the department of inspections and appeals.

73.13(4) *Notice of hearing.* The administrative law judge (ALJ) shall schedule the time, place and date of the hearing as expeditiously as possible. Hearings shall be conducted by telephone or in person in Des Moines, Iowa, at the Lucas State Office Building or other suitable location.

73.13(5) *Conduct of hearing.* The hearing shall be conducted according to the procedural rules of the department of inspections and appeals found in 481—Chapter 10, Iowa Administrative Code, and federal regulations found at 7 CFR 246.18. Copies of these regulations are available from the department of inspections and appeals upon request.

73.13(6) *Decision.* A written decision of the ALJ shall be issued, where possible, within 60 days from the date of the request for a hearing unless the parties agree to a longer period of time.

73.13(7) *Decision of ALJ.* When the ALJ makes a proposed decision and order, it shall be served by 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 as provided in subrule 73.13(8).

73.13(8) *Appeal to director.* Any appeal to the director for review of the proposed decision and order of the ALJ shall be filed in writing and mailed to the Director, Iowa Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075, by certified mail, return receipt requested, or delivered by personal service within ten days after the receipt of the ALJ's proposed decision and order

by the aggrieved party. A copy of the appeal shall also be mailed to the ALJ. Any request for an appeal shall state the reason for appeal.

73.13(9) *Record of hearing.* Upon receipt of an appeal request, the ALJ 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 hearing officer.

73.13(10) *Decision of director.* 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 certified mail, return receipt requested, or by personal service.

73.13(11) *Exhausting administrative remedies.* 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 decision of the department who has exhausted all administrative remedies may petition for judicial review pursuant to Iowa Code chapter 17A.

73.13(12) *Petition for judicial review.* 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 petition for judicial review shall be sent to the department by certified mail, return receipt requested, or by personal service. The address is: Division Director, Division of Health Promotion and Chronic Disease Prevention, Iowa Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075.

[**ARC 2839C**, IAB 12/7/16, effective 1/11/17]

641—73.14(135) State monitoring of contract agencies. The department shall review contract agency operations through use of reports and documents submitted, state-generated data processing reports, and on-site visits for evaluation and technical assistance.

73.14(1) *On-site visits.* Department staff shall visit contract agencies whenever necessary, to review operations and ensure compliance with state and federal regulations.

73.14(2) *Request for written reports.* The department may request written progress reports from contract agencies within specified times.

73.14(3) *Qualifications of department reviewers.* At minimum, one of the persons from the department responsible for reviewing a contract agency shall be a licensed dietitian.

641—73.15(135) Migrant services. To meet the WIC needs of migrant workers within the state, a contract or work agreement shall be maintained with at least one contract migrant service agency within the state to provide or assist in the provision of service to this population.

641—73.16(135) Civil rights. The Iowa WIC program shall operate in compliance with state and federal regulations to ensure the rights of all individuals under the WIC program.

[**ARC 2839C**, IAB 12/7/16, effective 1/11/17]

641—73.17(135) Audits. Each contract agency shall ensure an audit of the WIC program within the agency at least every two years, to be conducted by a private certified public accountant or in accord with applicable Office of Management and Budget Circulars: A-128, Audits of State and Local Governments, and A-133, Audits of Institutions of Higher Education and Other Nonprofit Institutions. Each audit shall cover all unaudited periods through the end of the previous grant year. The department's audit guide shall be followed to ensure an audit that meets federal and state requirements.

641—73.18(135) Reporting. Completion of grant applications, budgets, expenditure reports and written responses to the department's monitoring for the WIC program shall be conducted by contract agencies

in compliance with the formats and procedures outlined by the department in the Iowa WIC Policy and Procedure Manual, as specified in the contract entered into by the department and the contract agency.

641—73.19(135) WIC program violation. Participants or vendors are subject to the sanctions outlined below if determined by contract agency or department staff to be guilty of abusing the WIC program or its regulations.

73.19(1) *Participant violation.* Violations may be detected by contract agency staff, by vendors, or by department staff. Information obtained by the department is forwarded to the contract agency for appropriate action.

a. Whenever possible, the participant is counseled in person concerning the violation. Documentation is maintained according to procedures set forth in the Iowa WIC Policy and Procedure Manual.

b. Participants who violate WIC program regulations are subject to sanction in accordance with the schedule below:

Violation		Points Per Event
1.	Attempting to purchase unauthorized brands/types of foods (i.e., incorrect brands of cereal, juices, etc.).	3
2.	Attempting to cash food instruments outside of valid dates.	4
3.	Attempting to redeem WIC food instruments at an unauthorized vendor.	4
4.	Redeeming WIC food instruments that were reported as lost or stolen.	5
5.	Attempting to purchase more than the quantity of foods specified in the food benefits.	5
6.	Verbal abuse or harassment of WIC or vendor employees.	5
7.	Verbal abuse or harassment on social media.	5
8.	Threat of physical abuse of WIC or vendor employees.	10
9.	Threat of physical abuse of WIC or vendor employees on social media.	10
10.	Attempting to sell, return, or exchange foods for cash or credit.	10
11.	Attempting to purchase unauthorized (non-WIC) foods, such as meat, canned goods, etc.	10
12.	Attempting to purchase items that are not food.	10
13.	Sale or exchange of WIC food instruments for cash or credit or giving away WIC foods.	10
14.	Attempting to redeem food instrument issued to another participant.	10
15.	Receiving more than one set of benefits for the same time period.	10
16.	Knowing and deliberate misrepresentation of circumstances to obtain benefits (resulting in a false determination of eligibility).	10
17.	Attempting to steal WIC food instruments from a contract agency or participant.	10
18.	Physical abuse of WIC contract agency or vendor employees.	10
19.	Attempting to pick up food instruments for a child that is not currently in their care.	10
20.	Other violations of this chapter or the Iowa WIC Policy and Procedure Manual.	

c. The accumulation of 10 violation points within a 12-month period will result in a 2-month disqualification.

The accumulation of 10 additional violation points within a 12-month period following the disqualification will result in a 3-month disqualification. The participant must then reapply for the WIC program and be scheduled for a certification.

d. Fifteen days' notice must be given prior to all disqualifications. In all cases, the participant must be informed of the reason for the disqualification, of the right to appeal the decision through the

fair hearing process, and of eligibility to reapply for the WIC program at the end of the disqualification period.

e. A disqualification generally applies to all members of a family who are on the WIC program. The competent professional authority may waive the disqualification for one or more members of the family if it is determined that a serious health risk may result from WIC program disqualification. The reason for this waiver must be documented in the participant's file.

f. Violations are cumulative.

g. When a participant improperly received benefits as a result of intentionally making a false or misleading statement or intentionally misrepresenting, concealing, or withholding facts, the department shall collect the cash value of the improperly used food instruments. Collection of overpayment is not required when the department determines it is not cost-effective to do so.

The contract agency shall issue a written notice of restitution and disqualification. The written notice lists the serial numbers and dollar value of the food instruments for which payment is required.

The participant is required to surrender any unspent food instruments and send payment to the department in check or money order for those food instruments that have been cashed.

h. Each contract agency shall maintain a master list of all participant violation notices, disqualifications, and statements of restitution. The participant's notice of violation must also indicate when it is a second offense.

73.19(2) *Vendor violations.* There are five types of sanctions that are applied to vendors for violations of WIC program regulations: nonpayment of food instruments, issuance of violation points, temporary disqualification, permanent disqualification, and civil money penalties.

a. Nonpayment of food instruments. If the vendor has been terminated from the WIC program and submits a claim, it will be fully denied.

b. Administrative and procedural violation points. Administrative and procedural violations are offenses to the provisions of the WIC vendor agreement that do not rise to the level of fraud against the WIC program or its participants.

These violations are an indication of a vendor's inattention to or disregard of the requirements of a WIC vendor agreement. It is in the department's interest to record and consider these violations when considering whether to continue its contractual relationship with the vendor.

One or more transactions prior to notification of the vendor constitute only one violation if they contain the same error.

The assignment of violation points does not limit the department's right to effect stronger penalties and sanctions in cases in which there is evidence of an intentional or systematic practice of abusing or defrauding the Iowa WIC program.

Violation	Points Per Event
1. Developing and using promotional materials including stickers, tags, labels, or channel strips with the WIC service mark to identify WIC-approved foods.	5
2. Developing and using vendor-created WIC vendor identification decals to indicate vendor is an authorized vendor.	5
3. Failure to allow WIC participants to leave the vendor with WIC foods that were debited/removed from their eWIC account during a WIC transaction.	5
4. Failure to post eWIC signs in the cash register lane that has a working WIC terminal if the vendor is not integrated.	5
5. Failure to provide vendor ECR system participant receipts to WIC participants during each WIC transaction.	5
6. Failure to reimburse department for potentially overpaid food instrument or provide reasonable explanation for the cost of the food instrument.	10
7. Refusal to accept valid WIC food instruments from participants.	10

Violation		Points Per Event
8.	Discriminatory treatment of WIC participants, such as requiring WIC participants to use special checkout lanes or provide extra identification, or disallowing the use of coupons or other vendor discounts in WIC transactions that are allowed in non-WIC transactions.	10
9.	Treating WIC customers differently by offering them incentive items, vendor discounts, coupons, or other promotions that are not offered to non-WIC customers.	10
10.	Providing to WIC participants incentive items not prior authorized by the department.	10
11.	Failure to carry out corrective action plan developed as a result of monitoring visit.	10
12.	Accepting the return of food purchased with WIC food instruments for cash or credit toward other purchases.	10
13.	Issuing "rain checks" or credit in exchange for WIC food instruments.	10
14.	Stocking out-of-date, stale, or moldy WIC foods.	10
15.	Failure to submit vendor price assessment reports as requested.	10
16.	Failure to train all employees and ensure their knowledge regarding WIC program procedures set forth in the vendor's current agreement and in the current publication of the Iowa WIC program's vendor instruction booklet.	10
17.	Requiring WIC participants to purchase a particular brand when other WIC-approved brands are available.	10
18.	Not allowing WIC participants to use discount coupons or promotional specials to reduce the WIC food instrument amount.	10
19.	Requiring to enter the PIN for the participant and/or asking for the participant's PIN.	10
20.	For vendors that have special WIC prices, failure to post WIC prices on the shelf or on the package.	15
21.	Contacting WIC participants in an attempt to recover funds not paid by WIC.	15
22.	Providing false information on the price assessment report.	15
23.	Knowingly entering false information or altering information on the eWIC receipt/benefits.	10
24.	Requiring other cash purchases to redeem WIC food instruments.	15
25.	Failure to obtain infant and/or special needs formula from an approved source listed by the state WIC program.	15
26.	Offering incentive items with a value of more than $1.99.	15
27.	Scanning any UPC code that is not affixed to the actual item being purchased by the WIC participant.	20
28.	Failure to allow purchase of up to the full amount of WIC foods authorized on the food instrument if such foods are available and desired by the WIC participant.	20
29.	Other violations of this chapter or the vendor agreement or the Iowa WIC Policy and Procedure Manual.	

c. One-year disqualification. With an administrative finding of the following patterns of sanctions, the vendor will be disqualified for one year.

(1) A pattern of allowing purchase of nonapproved food items in exchange for WIC food instruments or for foods provided in excess of those listed on the WIC food instrument. (federally mandated sanction)

(2) Accumulation of 45 or more violations points within a single federal fiscal year of the agreement period. (department sanction)

(3) Failure to provide access to vendor premises or in any manner to hinder, impede or misinform authorized WIC personnel in the act of conducting an on-site education, monitoring or investigation visit. (department sanction)

(4) Loss of Iowa department of inspections and appeals license. (department sanction)

(5) Submitting for payment a WIC food instrument redeemed by another authorized vendor. (department sanction)

(6) Threatening or verbally abusing WIC participants or authorized WIC program personnel in the conduct of legitimate WIC program transactions. (department sanction)

(7) Submitting for payment WIC food instruments known by the vendor to have been lost or stolen. (department sanction)

(8) Participating with other individuals, including but not limited to WIC employees, vendors, and participants, in systematic efforts to submit false claims for reimbursement of improper WIC food instrument. (department sanction)

d. With an administrative finding of the following federally mandated sanctions, the vendor will be disqualified from being a WIC vendor for three years.

(1) A pattern of charging WIC participants more than non-WIC customers or charging WIC participants more than the current shelf price.

(2) A pattern of charging for items not received by the WIC participant or for foods provided in excess of those listed on the WIC food instrument.

(3) A pattern of providing credit or nonfood items, except for alcohol, alcoholic beverages, or tobacco products, in exchange for WIC food instruments.

(4) One incidence of allowing the purchase of alcohol, alcoholic beverages, or tobacco products with a WIC food instrument.

(5) A pattern of receiving, transacting, or redeeming WIC food instruments outside authorized channels, including through unauthorized vendors or persons.

(6) A pattern of claiming reimbursement for the sale of a quantity of a specific food item which exceeds the vendor's documented inventory of that food item for a specified period of time.

e. With an administrative finding of the following federally mandated sanctions, the vendor will be disqualified for six years.

(1) One incidence of buying or selling food instruments for cash (trafficking).

(2) One incidence of selling firearms, ammunition, explosives, or controlled substances (as defined in Section 102 of the Controlled Substances Act (21 U.S.C. 802)) in exchange for WIC food instruments.

f. With a conviction in a criminal court of law for trafficking in WIC food instruments or selling firearms, ammunition, explosives, or controlled substances (as defined in Section 102 of the Controlled Substances Act (21 U.S.C. 802)) in exchange for WIC food instruments, the vendor will be permanently disqualified from the Iowa WIC program. The department may impose a civil money penalty (CMP) in lieu of a disqualification when it determines, in its sole discretion, that:

(1) Disqualification of the vendor would result in inadequate participant access; or

(2) The vendor had, at the time of the violation, an effective policy and program in effect to prevent trafficking; and the ownership of the vendor was not aware of, did not approve of, and was not involved in the conduct of the violation.

g. The following items do not have a point value, but shall result in or extend a disqualification period:

(1) Failure to return WIC vendor stamp(s) to the WIC program within ten days of effective date of disqualification, or expiration of agreement following denial of subsequent application, shall result in a 30-day extension of a disqualification period.

(2) For each month in which a vendor accepts WIC food instruments during a disqualification period, the disqualification period shall be extended by 30 days.

h. The above sanctions notwithstanding, the state of Iowa reserves the right to seek civil and criminal prosecution of WIC vendors for any and all instances of dealing in stolen or lost food instruments, trading cash and other inappropriate commodities for food instruments, or cases in which

there exists evidence of a clear business practice to improperly obtain WIC funds, or other practices meeting the definition of fraud as defined in 7 CFR Part 246 or the Iowa Code.

i. A vendor shall not be entitled to receive any compensation for revenues lost as a result of any temporary or permanent disqualification.

j. A minimum of 15 days' notice is provided prior to all disqualifications, except for permanent disqualifications assessed under paragraph 73.19(2)*"f,"* which are effective on the date of receipt of the notice of administrative action. When the department determines that an offense has occurred, a disqualification letter with supporting documentation is prepared for the WIC director's signature. The disqualification letter identifies the specific offenses that the vendor is charged with and the procedures for filing an appeal. Voluntary withdrawal from the WIC vendor agreement to avoid a sanction is not allowed.

k. The department is responsible for issuing all warning and disqualification letters. Contract agencies are informed of all vendor correspondence regarding violations. In situations where participant violations are also involved, the contract agency is responsible for follow-up, as detailed in subrule 73.19(1).

l. Federal Supplemental Nutrition Assistance Program (SNAP) regulations require automatic disqualification from SNAP for vendors disqualified by the WIC program for certain types of violations. When a vendor is disqualified from the WIC program, the disqualification letter to the vendor will include the following statement: "This disqualification from WIC may result in disqualification as a retailer in the Supplemental Nutrition Assistance Program (SNAP). Such disqualification may not be subject to administrative or judicial review under SNAP." For all vendor disqualifications from the WIC program, notice will be sent to the United States Department of Agriculture for appropriate action.

m. The department shall disqualify a vendor who has been disqualified from SNAP. The disqualification shall be for the same length of time as the SNAP disqualification, may begin at a later date than the SNAP disqualification, and shall not be subject to administrative or judicial review under the WIC program. If the department determines that disqualification of a vendor would result in inadequate participant access, it will impose a civil money penalty (CMP) in lieu of disqualification.

n. Civil money penalties.

(1) When the department determines that a civil money penalty (CMP) shall be imposed in lieu of disqualification for reasons specified under paragraph 73.19(2)*"f"* or 73.19(2)*"m,"* it shall use the civil money penalty formula in accordance with Title 7 CFR 246.12(k)(1)(x) to determine the CMP.

(2) If a vendor does not pay, only partially pays, or fails to timely pay a CMP, the department will disqualify the vendor for the length of the disqualification corresponding to the violation for which the CMP was assessed. "Failure to timely pay a CMP" includes the failure to pay a CMP in accordance with an installment plan approved by the department.

(3) Money received by the state WIC agency as a result of civil money penalties or fines assessed against a vendor and any interest charged in the collection of these penalties and fines shall be considered as WIC program income.

[**ARC 2839C**, IAB 12/7/16, effective 1/11/17]

641—73.20(135) Data processing. All contract agencies shall comply with the instructions outlined in the Iowa WIC Policy and Procedure Manual for use of the automated data processing system in provision of WIC food instruments and monitoring of WIC services. No contract agency is exempted from adherence to any portion of these instructions.

641—73.21(135) Outreach. Outreach efforts within the Iowa WIC program shall be directed toward extension of services to the neediest Iowans of high priority by reason of their WIC status (see 7 CFR 246.1(d)(3)). The department and contract agencies shall share responsibility for the conduct of outreach efforts.

73.21(1) *Contract agency responsibilities.* Contract agencies shall conduct any or all of the following outreach activities annually:

a. Distribute WIC brochures to numerous community organizations and offices.

b. Complete outreach activities as specified in the local agency contract.

73.21(2) Reserved.

[**ARC 2839C**, IAB 12/7/16, effective 1/11/17]

641—73.22(135) Caseload management. The statewide caseload (number of participants) shall be managed by the department in accord with funding limitations and federal regulations or directives. The federally established priority categories of participant shall be followed when limitation of services is necessary in accord with 7 CFR 246.7(d)(3). In addition the following rules shall apply:

73.22(1) A contract agency shall maintain a waiting list only when the department determines that sufficient funds are not available to meet demand.

73.22(2) When a waiting list has been authorized, contract agencies shall certify applicants of potential highest priority first (e.g., women and infants) and potential lower priority second (children). Within these priority groups, applicants shall be offered certification appointments in the order of placement on the list.

73.22(3) When insufficient funds are available to serve all priority categories, the department shall provide instructions to contract agencies regarding which priority categories may continue to be certified.

73.22(4) When necessitated by federal funding restrictions, the department reserves the right to terminate or temporarily suspend benefits for categories of participants prior to the end of their certification period. Each participant shall be advised in writing 15 days before the effective date of the reasons for the action and of the right to a fair hearing.

[**ARC 2839C**, IAB 12/7/16, effective 1/11/17]

641—73.23(135) Grant application procedures for contract agencies. Private, nonprofit or public agencies wishing to provide WIC services shall file a letter of intent to make application to the department no later than April 1 of the competitive year. Applications shall be to administer WIC services for a specified project period, as defined in the request for proposal, with an annual continuation application. The contract period shall be from October 1 to September 30 annually. All materials submitted as part of the grant application are considered public records in accordance with Iowa Code chapter 22, after a notice of award is made by the department. Notification of the availability of funds and grant application procedures will be provided in accordance with the department rules found in 641—Chapter 176.

Contract agencies are selected on the basis of the grant applications submitted to the department. The department will consider only applications from private, nonprofit or public agencies. In the case of competing applications, the contract will be awarded to the agency that scores the highest number of points in the review. Copies of review criteria are available from: Chief, Bureau of Nutrition and Health Promotion, Iowa Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075; (515)281-7095 or 1-800-532-1579.

[**ARC 2839C**, IAB 12/7/16, effective 1/11/17]

641—73.24(135) Participant rights. The special supplemental nutrition program for women, infants and children shall be open to all eligible persons regardless of race, color, sex, creed, age, mental/physical handicap or national origin. The USDA Nondiscrimination Statement can be found on the following USDA Web site: http://www.fns.usda.gov/sites/default/files/cr/Nondiscrimination-Statement.pdf.

[**ARC 2839C**, IAB 12/7/16, effective 1/11/17]

641—73.25(135) Confidentiality. The department and local agencies shall protect the confidentiality of participant, applicant, and vendor information in accordance with 7 CFR Part 246.

[**ARC 2839C**, IAB 12/7/16, effective 1/11/17]

These rules are intended to implement federal law 42 U.S.C. Section 1786, and Iowa Code section 135.11(12).

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1 See IAB, Inspections and Appeals Department.
2 Effective date delayed 70 days by the Administrative Rules Review Committee at its March 8, 1988, meeting.

CHAPTER 77
LOCAL BOARDS OF HEALTH
[Prior to 7/29/87, Health Department[470] Ch 77]

641—77.1(137) Purpose. The local board of health shall have jurisdiction over public health matters within its designated geographic area in accordance with Iowa Code chapter 137. The local board of health shall promote and protect the health of the residents and shall carry out the powers of local boards as specified in Iowa Code sections 137.103 and 137.104 and all applicable Iowa Code chapters.
[**ARC 9773B**, IAB 10/5/11, effective 11/9/11]

641—77.2(137) Definitions. For the purpose of these rules, the following definitions apply:

"Core public health functions" means the functions of assessment, policy development, and assurance.

1. Assessment: Regular collection, analysis, interpretation, and communication of information about health conditions, risks, and assets in a community.
2. Policy development: Development, implementation, and evaluation of plans and policies, for public health in general and priority health needs in particular, in a manner that incorporates scientific information and community values and in accordance with state public health policy.
3. Assurance: Ensuring by encouragement, regulation, or direct action that programs and interventions that maintain and improve health are carried out.

"County health department" refers to the personnel and property under the jurisdiction of a county board.

"Department" means the Iowa department of public health.

"District" means any two or more geographically contiguous counties.

"District board" means a board of health representing at least two geographically contiguous counties formed with the approval of the department in accordance with Iowa Code chapter 137, or any district board of health in existence prior to July 1, 2010.

"District health department" refers to the personnel and property under the jurisdiction of a district board.

"Environmental health services" means services focused on the environment to support population-based health services.

"Essential public health services" means those activities carried out by public health that fulfill the core functions.

"Local board of health" means a city, county, or district board of health.

"Personal health services" means services focused on the care of individuals.

"Population-based health services" means services focused on the health status of population groups and their environments.
[**ARC 9773B**, IAB 10/5/11, effective 11/9/11; **ARC 2840C**, IAB 12/7/16, effective 1/11/17]

641—77.3(137) Local boards of health—roles and responsibilities. Public health is responsible for safeguarding the community's health. This goal is pursued through three core functions: assessment, policy development and assurance.

77.3(1) Assessment: Regularly and systematically collect, assemble, analyze, and make available information on the health of the community, including statistics on health status, community health needs, personal health services, and epidemiologic and other studies of health problems. A local board of health may perform the following essential public health services:

a. Monitor health status to identify community health problems;

b. Diagnose and investigate health problems and health hazards in the community; and

c. Evaluate effectiveness, accessibility, and quality of personal, population-based, and environmental health services.

77.3(2) Policy development: Exercise responsibility to serve the public interest in the development of comprehensive public health policies. This core function can be accomplished by promoting use of a

scientific knowledge base in decision making about public health and by taking the lead in public health policy development.

a. A local board of health may perform the following essential public health services:

(1) Develop policies and plans that support individual and community health efforts; and

(2) Research new insights and innovative solutions to health problems and health threats.

b. A local board of health shall perform the following essential public health services:

(1) Enforce laws and regulations that protect public health and enforce lawful orders of the department;

(2) Make and enforce reasonable rules and regulations not inconsistent with the law or the rules of the state board as may be necessary for the protection and improvement of the public health; and

(3) Employ persons as necessary for the efficient discharge of the board's duties. Employment practices shall meet the requirements of Iowa Code chapter 8A, subchapter IV, or any civil service provision adopted under Iowa Code chapter 400.

77.3(3) Assurance: Assure constituents that services necessary to achieve agreed-upon goals are provided either by encouraging action by other entities (private or public sector), by requiring such action through regulation, or by providing services directly. Each local board of health must involve key policymakers and the general public in determining a set of high-priority personal and population-based health services. A local board of health may perform the following essential public health services:

a. Link people to needed personal health services; provide such personal, population-based and environmental health services as deemed necessary for the promotion and protection of the health of the public; and charge reasonable fees for personal health services;

b. Ensure the competence of the public health, environmental health, and personal health care workforce;

c. Inform, educate, and empower people about health issues;

d. Mobilize community partnerships to identify and solve health problems;

e. Issue licenses and permits and charge reasonable fees in relation to the construction or operation of nonpublic water supplies or private sewage disposal systems;

f. Engage in joint operations by:

(1) Contracting with colleges and universities, the department, other public, private, and nonprofit agencies, and individuals; or

(2) Forming a district health department to provide personal and population-based health services; and

g. Enforce, by written agreement with the council of any city within its jurisdiction, appropriate ordinances of the city relating to public health.

[**ARC 9773B**, IAB 10/5/11, effective 11/9/11; **ARC 2840C**, IAB 12/7/16, effective 1/11/17]

641—77.4(137) Organization of local boards of health.

77.4(1) *Qualifications.* Members of a local board of health should have experience or education related to the core public health functions, essential public health services, public health, environmental health services, personal health services, population-based services, or community-based initiatives.

77.4(2) *Officers of local boards of health.* Each local board of health shall, at its first meeting during any calendar year, elect one of its members to serve as chairperson until the first meeting of the following calendar year.

a. The local board of health may elect a vice-chairperson, secretary, or other such officers as it may deem advisable.

b. In case of a vacancy of the office of chairperson, a successor, who shall serve the remainder of the term, shall be elected at the next meeting of the board.

77.4(3) *Meetings of local boards of health.* The place, date and time of regular meetings of the local board of health shall be determined by vote of the board, and such meetings shall comply with the provisions of the open meetings law which is found in Iowa Code chapter 21.

a. Each local board of health shall meet at least six times per year.

b. Special meetings of a local board of health may be called, as needed, by the chairperson or by any three board members. The local board of health shall provide at least 24 hours' notice of special meetings, except in case of emergency.

c. A majority of the members of a local board of health shall be considered a quorum, and an affirmative vote of the majority of the members present is necessary for action taken by a local board of health. The majority shall not include any member who has a conflict of interest, and a statement by the member that a conflict of interest exists shall be conclusive for this purpose.

[**ARC 9773B**, IAB 10/5/11, effective 11/9/11; **ARC 2840C**, IAB 12/7/16, effective 1/11/17]

641—77.5(137) Operation of local boards of health. Local boards of health shall submit to the department the following information:

77.5(1) Names, addresses, E-mail addresses and telephone numbers of members of the local board of health, within one month after their appointment.

77.5(2) Names of the chairperson and any other officers elected by the local board of health, within one month after their election.

77.5(3) A copy of the minutes of each regular and special meeting of the local board of health, within two weeks of their being approved. The minutes shall include at least:

a. The date and place of the meeting;

b. A list of members present; and

c. A report of any official board actions.

[**ARC 9773B**, IAB 10/5/11, effective 11/9/11; **ARC 2840C**, IAB 12/7/16, effective 1/11/17]

641—77.6(137) Expenses of local board of health members.

77.6(1) The following may be considered necessary expenses of local board of health members:

a. Travel in private car on local board of health business at the same rate as provided for a public officer or employee in Iowa Code section 70A.9.

b. Lodging and meal expenses including sales tax on lodging and meals.

c. Expense of public transportation when traveling on local board of health business.

d. Miscellaneous expenses related to performance of duties as approved by the local board of health.

e. Training and education expenses.

77.6(2) This rule shall not be construed as requiring the payment of reimbursement to any person or as prohibiting local boards of health from imposing additional restrictions or administrative requirements on expenses of their members.

[**ARC 9773B**, IAB 10/5/11, effective 11/9/11; **ARC 2840C**, IAB 12/7/16, effective 1/11/17]

641—77.7(137) Dissolution of city boards. A city board of health may voluntarily dissolve by submitting notice to the department. The notice shall set an effective date for the action.

[**ARC 2840C**, IAB 12/7/16, effective 1/11/17]

641—77.8(137) Request to form district board of health. The county boards of health of any two or more geographically contiguous counties may at any time submit to the department a written request to form a district board of health.

77.8(1) A request to form a district board of health shall be executed by the county board of supervisors and the county board of health for each county comprising the proposed district.

77.8(2) A request to form a district board of health shall be submitted to the department and shall be completed on the department's application form. The application form shall include:

a. A written narrative that explains how the formation of a district board of health will attain the capability to provide population-based and personal health services.

b. The composition of the district board of health, including the number of members each county shall appoint pursuant to Iowa Code section 137.105 and the total number of members on the district board of health.

c. Proof of approval by all county boards of supervisors and county boards of health involved in the request to form a district and of the elements included in the formation plan.

d. A service delivery plan. The service delivery plan shall detail how population-based and environmental health services will be delivered throughout the district.

e. The budget and fiscal plan for the proposed district health department. The budget plan shall include an estimate of the proposed expenditures and revenues and an allocation of the revenue responsibilities of each of the counties participating in the proposed district.

f. A table of organization.

g. A personnel system description, including identification of the district health department treasurer and district health department auditor and a section which addresses the employment issues contained in Iowa Code section 137.110.

h. The location of the district health department offices and workforce throughout the jurisdiction. The request shall include a map showing district boundaries.

i. An inventory of the property and equipment in the custody of each county health department and a description as to whether such property and equipment shall remain in the custody of the county health department or shall be transferred to the district health department to become property of the district health department. Property and equipment include any item which costs more than $5,000.

j. An information technology (IT) plan.

k. A proposed date upon which the district board of health shall be formed and established and a timeline for the adoption of district board of health rules and regulations.

[**ARC 9773B**, IAB 10/5/11, effective 11/9/11; **ARC 2840C**, IAB 12/7/16, effective 1/11/17]

641—77.9(137) Review, approval or denial of district board of health formation.

77.9(1) Upon receipt of the application form and all information contained in rule 641—77.8(137), the department shall review such information and shall determine, within 30 days, whether the required elements have been presented by the proposed district.

77.9(2) The department shall present its findings to the state board of health at the board's next regularly scheduled meeting, at which time the state board of health may approve formation of the district board of health.

77.9(3) The state board of health shall immediately provide notice of approval of district board of health formation, including effective dates, to the county board of health of each county in the district and to the board of supervisors of each county in the district.

77.9(4) Upon receipt of the notice of approval of district board of health formation, each appointing authority shall, prior to the effective date of district board of health formation, appoint district board of health members as specified in Iowa Code section 137.105.

77.9(5) The state board of health has the authority to deny formation of a district board of health if the application fails to conform with Iowa Code chapter 137 as amended by 2016 Iowa Acts, Senate File 2159, or this chapter.

77.9(6) The department will notify, in writing, all local boards of health in the proposed district of the reason and rationale for the denial of the district board of health formation within 30 days of the decision.

77.9(7) The local boards of health in the proposed district shall have the right to request reconsideration of the decision by submitting the request to the department within 30 days of receiving notice of the decision.

77.9(8) The state board of health shall reconsider the request by the local boards of health at its next regularly scheduled meeting. The reconsideration shall not constitute a contested case hearing. The state board of health's final decision following reconsideration shall constitute final agency action pursuant to Iowa Code section 17A.19, and judicial review of any such decision shall be treated as other agency action.

[**ARC 9773B**, IAB 10/5/11, effective 11/9/11; **ARC 2840C**, IAB 12/7/16, effective 1/11/17]

641—77.10(137) Adding to a district board of health. A county may be added to an existing district board of health by submission and approval of a request, as specified in Iowa Code sections 137.106 and 137.107.
[**ARC 9773B**, IAB 10/5/11, effective 11/9/11; **ARC 2840C**, IAB 12/7/16, effective 1/11/17]

641—77.11(137) Withdrawal from a district board of health. A county may voluntarily withdraw from a district board of health by submitting a request for withdrawal to the department for approval. The request shall include a time line and plan to reestablish a county board of health or to join a different district board of health to provide the core public health functions and essential public health services to the county's geographic area.

77.11(1) If the request for withdrawal of the applicant county from the district board of health is approved by the state board of health, an effective date shall be set for the action, and notification shall be sent to the district board of health and the board of supervisors of the applicant county.

77.11(2) The ownership of property and equipment shall follow the guidelines submitted in the original request to form the district board of health.

77.11(3) The remaining counties in the district shall submit an application including the information specified in rule 641—77.8(137) to the department for review as provided in Iowa Code section 137.107.
[**ARC 9773B**, IAB 10/5/11, effective 11/9/11; **ARC 2840C**, IAB 12/7/16, effective 1/11/17]

These rules are intended to implement Iowa Code chapter 137.

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CHAPTER 127
COUNTY MEDICAL EXAMINERS
[Prior to 7/29/87, Health Department [470] Ch 127]

641—127.1(144,331,691) Definitions.

"Autopsy" means the external and internal postmortem examination of a deceased person.

"Cause of death" means the disease or injury which sets in motion the chain of events which eventually result in the death of a person. The physician shall consider "but for" this injury or disease the person would still be living.

"County medical examiner" or *"CME"* means a medical or osteopathic physician or surgeon licensed in the state of Iowa and appointed by the board of supervisors to serve in this capacity.

"County medical examiner investigator" or *"CME-I"* means an individual appointed by a county medical examiner, with approval by the board of supervisors and the state medical examiner, to serve under the supervision of a county medical examiner to assist in death investigations.

"County of appointment" means the county which requests a medical examiner to conduct an investigation, perform or order an autopsy, or prepare a report(s) in a death investigation case. The request may be authorized by the county attorney or the county medical examiner. The county of appointment shall be the county in which the death occurred.

"Cremation" means the technical process, using heat and flame, that reduces human remains to bone fragments.

"Day" means calendar day.

"Death" means the condition as described in Iowa Code section 702.8.

"Death affecting the public interest" means any death of a human being in which the circumstances are sudden, unexpected, violent, suspicious, or unattended, including but not limited to those deaths listed at Iowa Code section 331.802(3) and described as follows:

1. Violent death. Violent death includes homicide, suicide, or accidental death resulting from physical, mechanical, thermal, chemical, electrical, or radiation injury. A medical examiner's investigation and report are required irrespective of the period of survival following injury.
2. Death caused by criminal abortion, including self-induced.
3. Death related to disease thought to be virulent or contagious which may constitute a public hazard. Any such case investigated by a medical examiner shall be reported to the department and to the local health authority.
4. Death that has occurred unexpectedly or from an unexplained cause. This term includes the following situations:

- Death without prior medical conditions accounting for the death.
- Apparently instantaneous death without obvious cause.
- Death during or following an unexplained syncope or coma.
- Death during an unexplained, acute, or rapidly fatal illness.

5. Death of a person confined in a prison, jail, or correctional institution.
6. Death of a person when unattended by a physician during the period of 36 hours immediately preceding death.

- This term includes the following situations:

— Persons found dead without obvious or probable cause.

— Death when the person was unattended by a physician during a terminal illness.

— Fetal death unattended by a physician. A fetal death is a fetus born dead after a gestation period of 20 completed weeks or greater or a fetus which weighs 350 grams or more (Iowa Code section 144.29).

- This term does not include a prediagnosed terminal or bedfast case in which a physician has been in attendance within 30 days preceding the death.
- This term does not include a terminally ill patient who was admitted to and received services from a hospice program as defined in Iowa Code section 135J.1, if a physician or registered nurse employed by the program was in attendance within 30 days preceding the death.

7. Death of a person if the body is not claimed by a relative or friend.

8. Death of a person if the identity of the deceased is unknown.

9. Death of a child under the age of two years if death results from an unknown cause or if the circumstances surrounding the death indicate that sudden infant death syndrome may be the cause of death.

"Department" means the Iowa department of public health.

"Deputy county medical examiner" or *"DCME"* means an individual appointed by a county medical examiner, with approval by the board of supervisors and the state medical examiner, to assist the county medical examiner in the performance of the county medical examiner's duties.

"External examination" means a close inspection of the exterior of a deceased human body for the purpose of locating, describing, and delineating any and all injuries or other abnormalities. External examination of a body does not constitute an autopsy, even if toxicology samples are obtained.

"Fee" means an amount to be paid to a county medical examiner's office as determined by the board of supervisors of the county of appointment for completion of an investigation, autopsy, or report(s). Fees for services provided by the state medical examiner's office are established at 641—126.3(691).

"Form ME-1" means the Preliminary Report of Investigation by Medical Examiner form.

"Form ME-2" means the Medical Examiner Embalming Certificate form.

"Form ME-3" means the Permit by Medical Examiner for Autopsy form.

"Form ME-4" means the Preliminary Report of Child/Infant Death Scene Investigation form.

"Form ME-5" means the Cremation Permit by Medical Examiner form.

"Form ME-6" means the Iowa State Medical Examiner's Office Personal Effects form.

"Form ME-7" means the Medication List form.

"Form ME-8" means the Body Identification Record form.

"Manner of death" means the circumstances under which the cause of death occurred and may be specified as follows: natural, accident, suicide, homicide, undetermined, or pending.

"Medical care provider" means an individual licensed or certified in any medical profession, including but not limited to a physician, physician assistant, nurse, emergency medical care provider, certified nurse's aide, pharmacist, physical therapist, and medical technologist.

"Medical examiner" means the state medical examiner, deputy state medical examiner, county medical examiner, or deputy county medical examiner.

641—127.2(331,691) Duties of medical examiners—jurisdiction over deaths which affect the public interest.

127.2(1) *Jurisdiction.* Upon receiving notification of a death which affects the public interest, a medical examiner shall notify any appropriate law enforcement agency not otherwise notified and shall take charge of the body of the decedent. The body shall not be disturbed or removed from the position in which it was found without authorization from the medical examiner except for the purpose of preserving the body from loss or destruction or permitting the passage of traffic on a highway, railroad, or airport, or unless the failure to remove the body might endanger life, safety, or health.

127.2(2) *Investigation.* A county medical examiner shall conduct a preliminary investigation of the cause and manner of death and shall utilize the investigative protocol outlined in the most current edition of the County Medical Examiner's Handbook, available from the state medical examiner's office. A medical examiner may perform or authorize performance of any scientific study to assist in identifying the cause, circumstances, and manner of death. A medical examiner shall cooperate with other investigating officials and agencies involved and shall share reports, information, and conclusions with these officials and agencies.

127.2(3) *Reports required.*

a. Form ME-1.

(1) Preparation and filing. A county medical examiner shall prepare a written report of the examiner's findings on the Preliminary Report of Investigation by Medical Examiner, Form ME-1. A county medical examiner shall file the original Form ME-1 with the state medical examiner's office within 14 days of the date of death and shall file a copy of the Form ME-1 with the county attorney within 14 days of the date of the death and shall retain a copy for the medical examiner's records.

(2) Content. Form ME-1 shall be completed as fully as possible in light of all available information and may be signed by either a county medical examiner or a county medical examiner investigator acting under the supervision of a county medical examiner. If the cause or manner of death, identity of the decedent, or other information is unknown or pending at the time of filing, "unknown" or "pending" may be written in the appropriate area of the form. If additional information becomes available, this information shall be forwarded to the state medical examiner in written form at such time as it becomes available to be added as a supplement to the file.

b. Jurisdiction declined or terminated. A form designated by the office of the state medical examiner shall be completed and filed in accordance with subparagraphs (1) and (2) of paragraph *"a"* above in cases reported to the county medical examiner where jurisdiction is terminated or declined.

127.2(4) *Disposition of body.* After an investigation, including an autopsy if one was performed, the body of the decedent shall be made available to the funeral home designated by a relative or friend of the decedent for burial or appropriate disposition. A medical examiner shall not use influence in favor of a particular funeral director or funeral home. If no one claims a body, it shall be disposed of as provided in Iowa Code chapter 142.

127.2(5) *Coverage.*

a. When an individual is required to report a death to a medical examiner and the county medical examiner cannot be located or is not available, the individual shall contact a county medical examiner from any adjacent Iowa county to perform those duties outlined in this chapter. The responding medical examiner shall have full authority to conduct any procedures necessary to the investigation of the cause and manner of death. If an adjacent county medical examiner is not available, the state medical examiner shall be contacted and may act in the capacity of a county medical examiner.

b. The responding county medical examiner shall be reimbursed by the county for which the service is provided for all fees and expenses at the rate which is customarily paid by the county for which the service is provided or at a rate agreed upon by the medical examiner and the board of supervisors of the county for which the service is provided.

641—127.3(331,691) Autopsies.

127.3(1) *Autopsy required.* A county medical examiner shall perform an autopsy or order that an autopsy be performed in the following cases:

a. All cases of homicide or suspected homicide, irrespective of the period of survival following injury.

b. All cases in which the manner of death is undetermined.

c. All cases involving unidentified bodies.

d. All deaths of children under the age of two when there is not a clear cause of death, including suspected cases of sudden infant death syndrome. A summary of the findings of the autopsy shall be transmitted by the physician who performed the autopsy to the county medical examiner within two days of completion of the report. Autopsies performed on children under the age of two when the circumstances surrounding the death indicate that sudden infant death syndrome may be the cause of death or the cause of death is not clearly explained by known medical history shall conform to Form ME-4.

e. All work- and farm-related deaths unless there is an obvious natural cause of death.

f. All drowning deaths.

g. All deaths of commercial vehicle drivers that occur during the performance of their job duties.

h. Deaths due to poisoning.

i. Deaths of airplane pilots who die as a result of an airplane crash. The National Transportation Safety Board and the Federal Aviation Administration should be contacted prior to the autopsy to request specimen kit(s).

j. Deaths due to a natural disaster, including tornadoes and floods.

k. Deaths in a prison, jail or correctional institution or under police custody, where there is not a natural disease process that accounts for the death.

127.3(2) *Autopsy recommended.* It is recommended that a county medical examiner should perform an autopsy or order that an autopsy be performed in the following cases:

a. Deaths of adolescents less than 18 years of age when there is not a natural cause of death.

b. All cases which involve a motor vehicle crash, unless it is a single motor vehicle accident with no potential for litigation and there is an obvious cause of death or the injuries have been clearly documented by hospitalization.

c. Rescinded IAB 3/29/06, effective 5/3/06.

d. Deaths from suicide.

e. All pedestrian, bicycle, motorcycle, snowmobile, boating, watercraft, three- or four-wheeler or all-terrain vehicle fatalities.

f. Deaths due to failure of a consumer product.

g. Deaths due to a possible public health hazard.

h. Deaths due to drug or alcohol abuse or overdose.

i. Electrical- and lightning-related deaths.

j. Deaths from burns or smoke or soot inhalation.

k. All deaths related to exposure, such as hypothermia and hyperthermia.

l. All sport-related deaths, including but not limited to deaths from auto racing and deaths resulting from injuries sustained in football, basketball, baseball, softball, soccer, or other games or sports.

127.3(3) *Other deaths.* For those deaths not listed in subrule 127.3(1) or 127.3(2), a county medical examiner shall determine whether the public interest requires an autopsy and may perform an autopsy or order that an autopsy be performed. A county medical examiner may consult with the state medical examiner to assist in determining the need for an autopsy.

127.3(4) *Performance of autopsy.*

a. Who may authorize. Autopsies may be authorized by the state medical examiner, the county medical examiner for the county in which the death occurred or the county where any injury contributing to or causing the death was sustained, or the county attorney who would have jurisdiction in any criminal proceeding related to the death.

b. Who may perform. An autopsy shall be performed by a pathologist trained or with experience in forensic pathology, licensed to practice medicine and surgery or osteopathic medicine and surgery in the state of Iowa and board-certified by the American Board of Pathology, or under the direct supervision of a physician with these qualifications. If an autopsy is performed by a physician who does not satisfy these criteria and who is not performing under the direct supervision of a physician who satisfies these criteria, the physician shall submit a supplemental report with the Permit by Medical Examiner for Autopsy, Form ME-3, which details the specific training, education, and experience which qualify the physician to perform an autopsy. The following cases/types of deaths shall be transported to the office of the state medical examiner for autopsy unless otherwise approved by the state medical examiner:

(1) Deaths of adolescents through 18 years of age when there is not a known or preexisting natural cause of death.

(2) All cases of homicide or suspected homicide, irrespective of the period of survival following injury.

(3) Deaths of children under the age of 2 years if death results from an unknown cause or if the circumstances surrounding the death indicate that Sudden Infant Death Syndrome may be the cause of death.

(4) All suspicious suicides.

(5) All high-profile deaths including, but not limited to, deaths of elected officials in municipal, state or federal government.

(6) All deaths of inmates occurring in any institutions under the department of corrections as outlined in Iowa Code section 904.102, excluding those deaths that result from a pre-existing medical condition.

c. Permit required—Form ME-3. A medical examiner shall complete the Permit by Medical Examiner for Autopsy, Form ME-3. All reasonable efforts shall be made to complete the Form ME-3

prior to the performance of an autopsy and to submit the form with the body of the decedent or to submit the form via facsimile to the state medical examiner.

127.3(5) *Autopsy report.* A complete record of the findings of the autopsy shall be submitted to the state medical examiner's office, the county attorney of the county where the death occurred and the county attorney of the county where the injury contributing to or causing the death was sustained within 90 days following the date of death, unless unusual circumstances requiring further investigation or testing exist. The report filed shall include all diagrams, transcriptions of the autopsy observations and opinions, and toxicology reports.

127.3(6) *Out-of-state autopsy.* The body of a decedent may be sent out of state for an autopsy or postmortem examination only if the county medical examiner certifies in writing that the out-of-state autopsy or examination is necessary for any of the following reasons:

a. A forensic pathologist practicing in the state of Iowa is unavailable;

b. Requiring an in-state autopsy would cause financial hardship; or

c. Requiring an in-state autopsy would delay the funeral or burial more than three days.

127.3(7) *Retention and disposal of tissues, organs, and bodily fluids.* The office of the state medical examiner shall retain tissues, organs, and bodily fluids as necessary to determine the cause and manner of death or as deemed advisable by the state medical examiner for medical or public health investigation, teaching, or research. Tissues, organs, and bodily fluids shall be retained at a minimum for the time periods established by the National Association of Medical Examiners and may be retained for a longer time period at the discretion of the state medical examiner. Tissues, organs, and bodily fluids retained under this subrule shall be disposed of without the specific consent or notification of the legal next of kin and in accordance with applicable federal and state regulations including but not limited to OSHA-recommended biohazard and blood-borne pathogen standards. The anatomical material shall be removed from the laboratory premises through use of a contracted, licensed, and bonded medical waste removal service to a medical waste processing center for final disposition.

641—127.4(331,691) Fees.

127.4(1) *Payment of fee and expenses.*

a. A medical examiner shall receive from the county of appointment or the county of the decedent's residence a fee for each preliminary investigation and report submitted in a case in which a death affects the public interest. A county medical examiner shall also receive from the county of appointment or the county of the decedent's residence the examiner's actual expenses. The fee and expenses shall be submitted by the county medical examiner to the county of appointment, which may immediately pay the invoice or forward the invoice to the county of the decedent's residence for payment to the county medical examiner. If the county medical examiner does not receive payment from the county of the decedent's residence within 60 days of receiving the invoice, the county of appointment shall pay the invoice.

b. A pathologist or other physician who performs an autopsy under medical examiner authorization shall be paid for the services by the county of appointment.

c. Invoices produced for services performed by a county medical examiner, deputy county medical examiner or county medical examiner investigator shall be submitted as a joint invoice to the county of appointment when services were rendered in a case by multiple county medical examiner staff.

127.4(2) *Reimbursement.*

a. County of residence different from county of appointment—Iowa resident. The county of the decedent's residence shall reimburse the county of appointment for the fee and expenses paid by the county of appointment.

b. Death caused by criminal defendant. If the person's death is caused by a criminal defendant who has been convicted and sentenced for murder, voluntary manslaughter, involuntary manslaughter, or homicide by vehicle, the county of the person's residence may recover from the defendant the fee and expenses.

c. Out-of-state resident—law enforcement involvement. The fee and expenses of a county medical examiner who performs an investigation or autopsy of a person who dies after being brought into the

state for emergency medical treatment by or at the direction of an out-of-state law enforcement officer or public authority shall be paid by the state. A claim for payment shall be filed with the state appeal board.

d. Out-of-state resident—no law enforcement involvement. The fee and expenses of a county medical examiner who performs an investigation or autopsy of an out-of-state resident shall be paid by the county of appointment.

e. Child under the age of two. Rescinded IAB 4/2/14, effective 5/7/14.

[**ARC 1403C**, IAB 4/2/14, effective 5/7/14; **ARC 2841C**, IAB 12/7/16, effective 1/11/17]

641—127.5(144,331,691) Death certificates—deaths affecting the public interest.

127.5(1) *Completion.* The funeral director to whom the body is released shall complete the personal data on the death certificate. The medical examiner shall complete the manner of death and cause of death sections of the death certificate within 72 hours after determination of the cause of death. If an autopsy is performed by the state medical examiner, the death certificate shall be submitted to the state medical examiner's office for completion. All information included on the certificate shall be typewritten.

127.5(2) *Filing.* The funeral director shall file the certificate with the county registrar in the county in which the death occurred. A death certificate shall be filed prior to the issuance of a burial transit permit and prior to disposal of the body.

127.5(3) *Extension of time.* If a medical examiner is unable to complete the manner of death and cause of death sections of the death certificate within the 24-hour time period, the funeral director shall file a death certificate form completed with all available information. Such certificate shall be authority for the issuance of a burial transit permit. Within 15 days, a supplemental report shall be filed with the local registrar which provides the information missing from the original certificate.

127.5(4) *Additional standards.* Additional rules relative to death certificates may be found at 641—Chapter 101.

641—127.6(331,691) Cremation.

127.6(1) *Permit obtained prior to cremation—Form ME-5.* A permit for cremation shall be obtained from a county medical examiner prior to cremation of a body of a decedent. For purposes of this requirement, a facsimile or electronic copy of the cremation permit has the same legal effect as the original. Cremation permits shall be issued on the Cremation Permit by Medical Examiner, Form ME-5.

127.6(2) *Requirements for issuance of permit.* A county medical examiner shall direct an inquiry into the cause and manner of death and shall determine whether the death is one which affects the public interest prior to issuing a cremation permit.

a. Death which affects the public interest. If the death occurred in a manner specified in Iowa Code section 331.802(3) or if reasonable suspicion that the death occurred in such a manner exists, a medical examiner shall view the body, make a personal inquiry into the cause and manner of death, and complete or cause to be completed all necessary autopsy or postmortem examinations prior to issuing a cremation permit.

b. Death which does not affect the public interest. If, following an inquiry into the cause and manner of death, the county medical examiner determines that the death did not occur in a manner specified in Iowa Code section 331.802(3), a medical examiner is not required to view the body prior to issuing a cremation permit. A county medical examiner shall certify on the Cremation Permit by Medical Examiner, Form ME-5, that the medical examiner's inquiry into the cause and manner of death did not disclose evidence that the death occurred in a manner specified in Iowa Code section 331.802(3).

127.6(3) *Fee.* A fee for the Cremation Permit by Medical Examiner, Form ME-5, shall be paid by the family, next of kin, guardian of the decedent, or other person authorized to act on behalf of the decedent.

641—127.7(331,691) County medical examiner investigators.

127.7(1) *Appointment.* A county medical examiner may appoint one or more county medical examiner investigators upon approval by the board of supervisors and the state medical examiner.

127.7(2) *Qualifications.*

a. Prior to appointment, a CME-I should possess a minimum of two years of experience as a licensed or certified nurse or medical care provider. A certified peace officer may be appointed to the position of CME-I if a nurse or medical care provider is not available.

b. A CME-I shall satisfy the following criteria:

(1) Prior to or within two years of appointment, attend the St. Louis University School of Medicine Basic Medicolegal Death Investigation Course or its state medical examiner-approved equivalent; and

(2) Prior to or within five years of appointment, obtain certification at the registry-level as a death investigator by the American Board of Medicolegal Death Investigators.

c. A CME-I is not required to meet the requirements of paragraph *"a"* or *"b"* if the individual has functioned in the capacity of a CME-I for a period of five years as of January 1, 2002.

d. If a CME is unable to appoint a CME-I who possesses the qualifications required by paragraph *"a," "b,"* or *"c,"* the CME may request a waiver. Waiver requests shall be submitted in writing to the state medical examiner and shall include the efforts undertaken by the CME to locate a CME-I who meets the above qualifications; the qualifications of the individual willing to serve in the capacity of CME-I; and the period of time for which the waiver is requested, not to exceed two years. The state medical examiner has sole discretion to waive the requirements of this rule and may withdraw or modify a waiver request upon a finding that the CME-I has failed to adequately perform the duties of the position or for other good cause.

e. If a CME-I is unable to meet the eligibility requirements for obtaining registry certification due to the small number of cases requiring investigation in the county of appointment, then a waiver shall be obtained from the state medical examiner in order for the investigator to continue his or her duties. The county medical examiner shall submit a request for a waiver in writing with documentation of the number of deaths occurring in the county of appointment which require death investigation. The waiver must be renewed every five years if the required number of investigations has still not been achieved.

127.7(3) *Duties.* A CME-I shall assist in death investigations. A CME-I acting under the supervision of a county medical examiner may sign the Form ME-1. A CME-I shall not sign a certificate of death or a Form ME-5.

127.7(4) *Supervision.* A CME-I shall serve under the supervision of a county medical examiner. A CME-I provides services under the direction of a county medical examiner or state medical examiner's office. A CME-I shall at all times perform services in a manner which is consistent with the protocol outlined in the most current edition of the County Medical Examiner's Handbook and any policies or protocols of the supervising county medical examiner.

127.7(5) *Fees.* Fees for the services provided by a CME-I shall be paid by the county of appointment or by the county of the decedent's residence. A CME-I shall also receive from the county of appointment or the county of the decedent's residence reimbursement for actual expenses. The fee and expenses shall be submitted by the CME-I to the county of appointment, which may immediately pay the invoice or forward the invoice to the county of the decedent's residence for payment to the CME-I. If the CME-I does not receive payment from the county of the decedent's residence within 60 days of receiving the invoice, the county of appointment shall pay the invoice.

[**ARC 8526B**, IAB 2/10/10, effective 3/17/10; **ARC 2841C**, IAB 12/7/16, effective 1/11/17]

641—127.8(331,691) Deputy county medical examiners.

127.8(1) *Appointment.* A county medical examiner may appoint one or more deputy county medical examiners upon approval by the board of supervisors and the state medical examiner.

127.8(2) *Qualifications.* A DCME shall be licensed in the state of Iowa as a medical or osteopathic physician or surgeon.

127.8(3) *Duties.* A DCME shall serve at the direction of the county medical examiner and may perform any duty of a county medical examiner which is delegated by the county medical examiner to the DCME.

127.8(4) *Fees.* Fees for the services provided by a DCME shall be paid by the county of appointment or by the county of the decedent's residence. A DCME shall also receive from the county of appointment or the county of the decedent's residence reimbursement for actual expenses. The fee and expenses shall

be submitted by the DCME to the county of appointment, which may immediately pay the invoice or forward the invoice to the county of the decedent's residence for payment to the DCME. If the DCME does not receive payment from the county of the decedent's residence within 60 days of receiving the invoice, the county of appointment shall pay the invoice.
[**ARC 2841C**, IAB 12/7/16, effective 1/11/17]

641—127.9(331,691) Failure to comply with rules. If a county medical examiner, deputy county medical examiner, county medical examiner investigator, pathologist, or other physician fails to comply with these rules, the state medical examiner may provide written notice of the failure to comply to that individual, the appropriate county medical examiner, and the appropriate county board of supervisors. Within 30 days of the date of the notice, the individual to whom the notice was provided shall submit a written response to the state medical examiner, outlining a proposed corrective action plan. If no response is received within the 30 days or if the proposed corrective action plan is unacceptable, the state medical examiner shall forward copies of the notice and all pertinent correspondence and information to the board of supervisors for the county which appointed the individual, notifying the board of the individual's failure to comply with these rules.

641—127.10(331,691,22) Confidentiality. Records and reports of a medical examiner may be confidential records pursuant to Iowa Code sections 22.7(2), 22.7(5), and 22.7(41) and other provisions of Iowa law. Prior to releasing a medical examiner record or report to a member of the public, a county medical examiner may inform the appropriate law enforcement agency, the county attorney, and the state medical examiner to determine whether release is authorized under Iowa law.

641—127.11(331,691,670) Indemnification. A board of supervisors shall defend, hold harmless, and indemnify a county medical examiner and any properly appointed staff members to the extent provided in Iowa Code chapter 670.

These rules are intended to implement Iowa Code chapters 331 and 691.

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BEHAVIORAL SCIENTISTS

CHAPTER 31
LICENSURE OF MARITAL AND FAMILY THERAPISTS AND MENTAL HEALTH COUNSELORS

[Prior to 1/30/02, see 645—Chapter 30]

645—31.1(154D) Definitions. For purposes of these rules, the following definitions shall apply:

"ACA" means the American Counseling Association.

"Active license" means a license that is current and has not expired.

"AMFTRB" means the Association of Marital and Family Therapy Regulatory Boards.

"Board" means the board of behavioral science.

"CCE" means the Center for Credentialing and Education, Inc.

"Course" means three graduate semester credit hours.

"Department" means the department of public health.

"Grace period" means the 30-day period following expiration of a license when the license is still considered to be active. In order to renew a license during the grace period, a licensee is required to pay a late fee.

"Inactive license" means a license that has expired because it was not renewed by the end of the grace period. The category of "inactive license" may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

"Licensee" means any person licensed to practice as a marital and family therapist or mental health counselor in the state of Iowa.

"License expiration date" means September 30 of even-numbered years.

"Licensure by endorsement" means the issuance of an Iowa license to practice mental health counseling or marital and family therapy to an applicant who is or has been licensed in another state.

"Mandatory training" means training on identifying and reporting child abuse or dependent adult abuse required of marital and family therapists and mental health counselors who are mandatory reporters. The full requirements on mandatory reporting of child abuse and the training requirements are found in Iowa Code section 232.69. The full requirements on mandatory reporting of dependent adult abuse and the training requirements are found in Iowa Code section 235B.16.

"Mental health setting" means a behavioral health setting where an applicant is providing mental health services including the diagnosis, treatment, and assessment of emotional and mental health disorders and issues.

"NBCC" means the National Board for Certified Counselors.

"Reactivate" or *"reactivation"* means the process as outlined in rule 645—31.16(17A,147,272C) by which an inactive license is restored to active status.

"Reciprocal license" means the issuance of an Iowa license to practice mental health counseling or marital and family therapy to an applicant who is currently licensed in another state which has the same or similar qualifications to those required in Iowa.

"Reinstatement" means the process as outlined in 645—11.31(272C) by which a licensee who has had a license suspended or revoked or who has voluntarily surrendered a license may apply to have the license reinstated, with or without conditions. Once the license is reinstated, the licensee may apply for active status.

"Temporary license" means a license to practice marital and family therapy or mental health counseling under direct supervision of a qualified supervisor as determined by the board by rule to fulfill the postgraduate supervised clinical experience requirement in accordance with this chapter.
[**ARC 9547B**, IAB 6/1/11, effective 7/6/11; **ARC 2845C**, IAB 12/7/16, effective 1/11/17]

645—31.2(154D) Requirements for permanent and temporary licensure. The following criteria shall apply to licensure:

31.2(1) The applicant shall complete a board-approved application. Application forms may be obtained from the board's Web site (https://www.idph.iowa.gov/licensure) or directly from the board office, or the applicant may complete the application online at https://ibplicense.iowa.gov. All paper applications shall be sent to the Board of Behavioral Science, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075.

31.2(2) The applicant shall complete the application form according to the instructions contained in the application. If the application is not completed according to the instructions, the application will not be reviewed by the board.

31.2(3) Each application shall be accompanied by the appropriate fees payable to the Board of Behavioral Science. The fees are nonrefundable.

31.2(4) No application will be considered by the board until official copies of academic transcripts sent directly from the school to the board of behavioral science have been received by the board or an equivalency evaluation completed by the Center for Credentialing and Education, Inc. (CCE) has been received by the board. The applicant shall present proof of meeting the educational requirements. Documentation of such proof shall be on file in the board office with the application and include one of the following:

a. For licensure as a marital and family therapist, an official transcript verifying completion of a marital and family therapy program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) as defined in subrule 31.4(1) or an equivalency evaluation of the applicant's educational credentials completed by CCE as defined in subrule 31.4(2).

b. For licensure as a mental health counselor, an official transcript verifying completion of a mental health counseling program accredited by the Council on Accreditation of Counseling and Related Educational Programs (CACREP) as defined in subrule 31.6(1) or an equivalency evaluation of the applicant's educational credentials completed by CCE as defined in subrule 31.6(2).

31.2(5) The candidate for permanent licensure shall have the examination score sent directly from the testing service to the board. The candidate for temporary licensure must successfully complete the examination before the temporary license is issued.

31.2(6) The candidate for permanent licensure shall submit the required attestation of supervision forms documenting clinical experience as required in rule 645—31.5(154D) for marital and family therapy and rule 645—31.7(154D) for mental health counseling.

31.2(7) The candidate for temporary licensure for the purpose of fulfilling the postgraduate supervised clinical experience requirement must submit the Supervised Clinical Experience: Approval and Attestation form to the board and receive approval of the candidate's supervisor(s) prior to licensure. The temporary licensee must notify the board immediately in writing of any proposed change in supervisor(s) and obtain approval of any change in supervisor(s). Within 30 days of completion of the supervised clinical experience, the attestation of the completed supervised experience must be submitted to the board office. The temporary licensee shall remain under supervision until a permanent license is issued.

31.2(8) A temporary license for the purpose of fulfilling the postgraduate supervised clinical experience requirement is valid for three years and may be renewed at the discretion of the board.

31.2(9) A licensee who was issued an initial permanent license within six months prior to the renewal shall not be required to renew the license until the renewal date two years later.

31.2(10) Submitting complete application materials. An application for a temporary or permanent license will be considered active for two years from the date the application is received. If the applicant does not submit all materials within this time period or if the applicant does not meet the requirements

for the license, the application shall be considered incomplete. An applicant whose application is filed incomplete must submit a new application, supporting materials, and the application fee. The board shall destroy incomplete applications after two years.
[**ARC 8152B**, IAB 9/23/09, effective 10/28/09; **ARC 0777C**, IAB 6/12/13, effective 7/17/13; **ARC 1758C**, IAB 12/10/14, effective 1/14/15; **ARC 2845C**, IAB 12/7/16, effective 1/11/17]

645—31.3(154D) Examination requirements. The following criteria shall apply to the written examination(s):

31.3(1) In order to qualify for licensing, the applicant:

a. For a marital and family therapist license shall take and pass the Association of Marital and Family Therapy Regulatory Board (AMFTRB) Examination in Marital and Family Therapy.

b. For a mental health counselor license shall take and pass the National Counselor Examination of the NBCC or the National Clinical Mental Health Counselor Examination of the NBCC.

31.3(2) Examination information will be provided when the applicant has been approved to take the examination.

31.3(3) The board will notify the applicant in writing of examination results.

31.3(4) Persons determined by the board not to have performed satisfactorily may apply for reexamination.

31.3(5) The passing score on the written examination shall be the passing point criterion established by the appropriate national testing authority at the time the test was administered.

31.3(6) An applicant who is requesting approval to take the licensure examination prior to graduation shall:

a. Apply for licensure by creating an account and paying online at https://ibplicense.iowa.gov or by completing and returning a paper application with a check or money order payable to the Board of Behavioral Science.

b. Have a letter on official school letterhead sent directly from the program director to the board indicating that the applicant is in good academic standing; that the applicant will graduate from the program within three months of the date on the letter; and the applicant's anticipated date of graduation.
[**ARC 2845C**, IAB 12/7/16, effective 1/11/17]

645—31.4(154D) Educational qualifications for marital and family therapists. The applicant must complete the required semester credit hours, or equivalent quarter hours, of graduate level coursework in each of the content areas identified in 31.4(2); no course may be used more than once. The applicant must present proof of completion of the following educational requirements for licensure as a marital and family therapist:

31.4(1) *Accredited program.* Applicants must present with the application an official transcript verifying completion of a master's degree of 60 semester hours (or 80 quarter hours or equivalent) or a doctoral degree in marital and family therapy from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) from a college or university accredited by an agency recognized by the United States Department of Education. Applicants who entered a program of study prior to July 1, 2010, must present with the application an official transcript verifying completion of a master's degree of 45 semester hours or the equivalent; or

31.4(2) *Content-equivalent program.* Applicants must present an official transcript verifying completion of a master's degree of 60 semester hours (or 80 quarter hours or equivalent) or a doctoral degree in marital and family therapy, behavioral science, or a counseling-related field from a college or university accredited by an agency recognized by the United States Department of Education, which is content-equivalent to a graduate degree in marital and family therapy. Applicants who entered a program of study prior to July 1, 2010, must present with the application an official transcript verifying completion of a master's degree of 45 semester hours or the equivalent. Graduates from non-COAMFTE-accredited marital and family therapy programs shall provide an equivalency evaluation of the graduates' educational credentials by the Center for Credentialing and Education, Inc. (CCE), Web site http://cce-global.org. The professional curriculum must be equivalent to that

stated in these rules. Applicants shall bear the expense of the curriculum evaluation. In order to qualify as a "content-equivalent" degree, a graduate transcript must document:

a. At least 9 semester hours or the equivalent in each of the three areas listed below:

(1) Theoretical foundations of marital and family therapy systems. Any course which deals primarily in areas such as family life cycle; theories of family development; marriage or the family; sociology of the family; families under stress; the contemporary family; family in a social context; the cross-cultural family; youth/adult/aging and the family; family subsystems; individual, interpersonal relationships (marital, parental, sibling).

(2) Assessment and treatment in family and marital therapy. Any course which deals primarily in areas such as family therapy methodology; family assessment; treatment and intervention methods; overview of major clinical theories of marital and family therapy, such as communications, contextual, experiential, object relations, strategic, structural, systemic, transgenerational.

(3) Human development. Any course which deals primarily in areas such as human development; personality theory; human sexuality. One course must be psychopathology.

b. At least 3 semester hours or the equivalent in each of the two areas listed below:

(1) Ethics and professional studies. Any course which deals primarily in areas such as professional socialization and the role of the professional organization; legal responsibilities and liabilities; independent practice and interprofessional cooperation; ethical issues in marital and family counseling; and family law.

(2) Research. Any course which deals primarily in areas such as research design, methods, statistics; research in marital and family studies and therapy.

If the applicant has taught a graduate-level course as outlined above at a college or university accredited by an agency recognized by the United States Department of Education or the Council on Professional Accreditation, that course will be credited toward the course requirements.

c. A graduate-level clinical practicum in marital and family therapy of at least 300 clock hours is required for all applicants.

[**ARC 7673B**, IAB 4/8/09, effective 4/30/09; **ARC 9547B**, IAB 6/1/11, effective 7/6/11; **ARC 2845C**, IAB 12/7/16, effective 1/11/17]

645—31.5(154D) Clinical experience requirements for marital and family therapists.

31.5(1) The supervised clinical experience shall:

a. Be a minimum of two years or the equivalent of full-time, postgraduate supervised professional work experience in marital and family therapy.

b. Be completed following completion of the practicum, internship, and all graduate coursework, with the exception of the thesis.

c. Include successful completion of at least 3,000 hours of marital and family therapy that shall include at least 1,500 hours of direct client contact and 200 hours of clinical supervision. Applicants who entered a program of study prior to July 1, 2010, shall include successful completion of 200 hours of clinical supervision concurrent with 1,000 hours of marital and family therapy conducted in person with couples, families and individuals.

d. Include a minimum of 25 percent of all clinical supervision in person.

(1) The first two meetings shall be face-to-face and in person.

(2) Up to 50 percent of all supervision may be completed by telephone.

(3) Up to 75 percent of all supervision may be completed by electronic means.

(4) Supervision by electronic means is acceptable if the system utilized is a confidential, interactive, secure, real-time system that provides for visual and audio interaction between the licensee and the supervisor.

e. Include in the 200 hours of clinical supervision at least 100 hours of individual supervision.

f. Follow and maintain a plan throughout the supervisory period established by the supervisor and the licensee. Such a plan must be kept by the licensee for a period of five years following receipt of the permanent license and must be submitted to the board upon request. The plan for supervision shall include:

(1) The name, license number, date of licensure, address, telephone number, and e-mail address (when available) of the supervisor;

(2) The name, license number, address, telephone number, and e-mail address (when available) of supervisee;

(3) Employment setting in which experience will occur;

(4) The nature, duration and frequency of supervision;

(5) The number of hours of supervision per month;

(6) The supervisor/licensees type (individual/group) and mode (face-to-face/electronic) of supervision;

(7) The methodology for secure transmission of case information;

(8) The beginning date of supervised professional practice and estimated date of completion;

(9) The goals and objectives for the supervised professional practice; and

(10) The signatures of the supervisor and licensee, and the dates of signatures.

g. Have only supervised clinical contact credited for this requirement.

31.5(2) To meet the requirements of the supervised clinical experience:

a. The supervisee must:

(1) Meet with the supervisor for a minimum of four hours per month;

(2) Offer documentation of supervised hours signed by the supervisor;

(3) Compute part-time employment on a prorated basis for the supervised professional experience;

(4) Have the background, training, and experience that is appropriate to the functions performed;

(5) Have supervision that is clearly distinguishable from personal psychotherapy and is contracted in order to serve professional/vocational goals;

(6) Have individual supervision that shall be in person with no more than one supervisor to two supervisees;

(7) Have group supervision that may be completed with up to ten supervisees and a supervisor; and

(8) Not participate in the following activities which are deemed unacceptable for clinical supervision:

1. Peer supervision, i.e., supervision by a person of equivalent, but not superior, qualifications, status, and experience.

2. Supervision, by current or former family members, or any other person, in which the nature of the personal relationship prevents, or makes difficult, the establishment of a professional relationship.

3. Administrative supervision, e.g., clinical practice performed under administrative rather than clinical supervision of an institutional director or executive.

4. A primarily didactic process wherein techniques or procedures are taught in a group setting, classroom, workshop, or seminar.

5. Consultation, staff development, or orientation to a field or program, or role-playing of family interrelationships as a substitute for current clinical practice in an appropriate clinical situation.

b. The supervisor shall:

(1) Be an Iowa-licensed marital and family therapist with a minimum of three years of clinical experience following licensure; or

(2) Be a supervisor or supervisor candidate approved by the American Association for Marriage and Family Therapy Commission on Supervision; or

(3) Be licensed under Iowa Code chapter 147 and have a minimum of three years of full-time professional work experience, including experience in marital and family therapy, as approved by the board; and

(4) Meet a minimum of four hours per month with the supervisee; and

(5) Provide training that is appropriate to the functions to be performed; and

(6) Ensure that therapeutic work is completed under the professional supervision of a supervisor; and

(7) Not supervise any marital and family therapy or permit the supervisee to engage in any therapy which the supervisor cannot perform competently.

c. Effective October 1, 2020, the supervisor shall:

(1) Be an Iowa-licensed marital and family therapist with a minimum of three years of clinical experience following licensure or shall be a supervisor or supervisor candidate approved by the American Association for Marriage and Family Therapy Commission on Supervision; or

(2) Be an Iowa-licensed mental health counselor in Iowa with at least three years of clinical experience following licensure or shall be approved by the National Board for Certified Counselors (NBCC) as a supervisor; and

(3) Have completed at least a six-hour continuing education course in counseling supervision or one master's level course in counseling supervision; and

(4) Meet a minimum of four hours per month with the supervisee; and

(5) Provide training that is appropriate to the functions to be performed; and

(6) Ensure that therapeutic work is completed under the professional supervision of a supervisor; and

(7) Not supervise any marital and family therapy or permit the supervisee to engage in any therapy that the supervisor cannot perform competently.

d. Exceptions to paragraph 31.5(2)*"c"* shall be made on an individual basis. Requests for alternative supervisors must be submitted in writing, and the board must approve the supervisor prior to commencement of the supervision.

31.5(3) An applicant who has obtained American Association for Marriage and Family Therapy (AAMFT) clinical membership is considered to have met the clinical experience requirements of rule 645—31.5(154D). The applicant shall request that proof of current clinical membership be sent directly from AAMFT to the board.

[**ARC 7673B**, IAB 4/8/09, effective 4/30/09; **ARC 8152B**, IAB 9/23/09, effective 10/28/09; **ARC 9547B**, IAB 6/1/11, effective 7/6/11; **ARC 0777C**, IAB 6/12/13, effective 7/17/13; **ARC 2845C**, IAB 12/7/16, effective 1/11/17]

645—31.6(154D) Educational qualifications for mental health counselors. The applicant must complete three semester credit hours, or equivalent quarter hours, of graduate level coursework in each of the content areas identified in 31.6(2); no course may be used to fulfill more than one content area. The applicant must present proof of completion of the following educational requirements for licensure as a mental health counselor:

31.6(1) *Accredited program.* Applicants must present with the application an official transcript verifying completion of a master's degree of 60 semester hours (or equivalent quarter hours) or a doctoral degree in counseling with emphasis in mental health counseling from a mental health counseling program accredited by the Council on Accreditation of Counseling and Related Educational Programs (CACREP) from a college or university accredited by an agency recognized by the United States Department of Education. Applicants who entered a program of study prior to July 1, 2012, must present with the application an official transcript verifying completion of a master's degree of 45 semester hours or the equivalent; or

31.6(2) *Content-equivalent program.* Applicants must present an official transcript verifying completion of a master's degree or a doctoral degree from a college or university accredited by an agency recognized by the United States Department of Education which is content-equivalent to a master's degree in counseling with emphasis in mental health counseling. Graduates from non-CACREP accredited mental health counseling programs shall provide an equivalency evaluation of their educational credentials by the Center for Credentialing and Education, Inc. (CCE), Web site http://cce-global.org. The professional curriculum must be equivalent to that stated in these rules. Applicants shall bear the expense of the curriculum evaluation.

a. The degree of an applicant who entered a program of study prior to July 1, 2012, will be considered "content-equivalent" if the degree includes 45 semester hours (or equivalent quarter hours) and successful completion of graduate-level coursework in each of the areas in subparagraphs (1) to (12). If the applicant has taught a graduate-level course in any of the areas in subparagraphs (1) to (12) at a college or university accredited by an agency recognized by the United States Department of Education, that course may be credited toward the coursework requirement.

(1) Counseling theories. Studies that provide an understanding of counseling theories, utilize personal and environmental data in the mental health counseling process, and investigate procedures that are appropriate to various counseling theories and specific settings.

(2) Supervised counseling practicum. A graduate-level clinical supervised counseling practicum in a mental health setting in which students must complete supervised practicum experiences that total a minimum of 100 clock hours over a minimum ten-week academic term. The practicum provides for the development of counseling skills under supervision. The student's practicum includes all of the following:

1. At least 40 hours of direct service with actual clients that contributes to the development of counseling skills;
2. Weekly interaction with an average of 1 hour per week of individual or triadic supervision throughout the practicum by a program faculty member, a student supervisor, or a site supervisor who is working in biweekly consultation with a program faculty member in accordance with the supervision contract;
3. An average of 1½ hours per week of group supervision that is provided on a regular schedule throughout the practicum by a program faculty member or a student supervisor; and
4. Evaluation of the student's counseling performance throughout the practicum, including documentation of a formal evaluation after the student completes the practicum.

(3) Human growth and development. Studies that provide an understanding of the nature and needs of individuals at all developmental levels. Studies in this area include, but are not limited to, the following:

1. Theories of human development across the life span;
2. Major theories of personality development; and
3. Human behavior, including an understanding of developmental crises, disability, psychopathology, and cultural factors as they affect both normal and abnormal behavior.

(4) Social and cultural foundations. Studies that provide an understanding of issues and trends in a multicultural and diverse society. Studies in this area include, but are not limited to, the following:

1. Multicultural and pluralistic trends, including characteristics and concerns of diverse groups;
2. Attitudes and behavior based on factors such as age, race, religious preference, physical disability, sexual orientation, ethnicity and culture, gender, socioeconomic status, and intellectual ability; and
3. Individual and group interventions with diverse populations.

(5) Helping relationships. Studies that provide an understanding of counseling and consultation processes. Studies in this area include, but are not limited to, the following:

1. Helping skills and counseling and consultation theories, including coverage of relevant research and factors considered in applications;
2. Counselor or consultant characteristics and behaviors that influence helping processes, including gender and ethnicity differences, verbal and nonverbal behaviors and personal characteristics, orientations, and skills; and
3. Client or consultee characteristics and behaviors that influence helping processes, including gender and ethnicity differences, verbal and nonverbal behaviors and personal characteristics, traits, capabilities, life circumstances, and developmental levels.

(6) Groups. Studies that provide an understanding of group development, dynamics, counseling theories, and group counseling methods and skills. Studies in this area include, but are not limited to, the following:

1. Principles of group dynamics, including group process components, developmental stage theories, and group members' roles and behaviors;
2. Group leadership styles and approaches, including characteristics of various types of group leaders and leadership styles;
3. Theories of group counseling, including commonalities, distinguishing characteristics, and pertinent research and literature; and

4. Group counseling methods, including group counselor orientations and behaviors, ethical considerations, appropriate selection criteria and methods, and methods of evaluation of effectiveness.

(7) Career and lifestyle development. Studies that provide an understanding of career development and the interrelationships among work, family, and other life factors. Studies in this area include, but are not limited to, the following:

1. Career development theories and decision-making models;
2. Career, avocational, educational and labor market sources, print media, computer-assisted career guidance, and computer-based career information;
3. Career development program planning;
4. Interrelationships among work, family, and other life factors such as multicultural and gender issues, as related to career development;
5. Career and educational placement, follow-up and evaluation; and
6. Assessment instruments relevant to career planning and decision making.

(8) Diagnosis and assessment treatment procedures. Studies that provide an understanding of individual and group approaches to assessment and evaluation. Studies in this area include, but are not limited to, the following:

1. Theoretical and historical bases for assessment techniques and methods of interpretation of appraisal data and information;
2. Types of educational and psychological appraisal as appropriate to the helping process;
3. Validity, including evidence for establishing content, construct, and empirical validity;
4. Reliability, including methods of establishing stability and internal and equivalence reliability;
5. Major appraisal methods, including environmental assessment, performance assessment, individual and group test and inventory methods, behavioral observations, and computer-managed and computer-assisted methods;
6. Psychometric statistics, including types of test scores, measures of central tendency, indices of variability, standard errors and correlations; and
7. Gender, ethnicity, language, disability, and cultural factors related to the assessment and evaluation of individuals and groups.

(9) Research and program evaluation. Studies that provide an understanding of types of research methods, basic statistics, and ethical and legal considerations in research. Studies in this area include, but are not limited to, the following:

1. Basic types of research methods, including qualitative, quantitative-descriptive, and quantitative-descriptive-experimental designs;
2. Basic statistics, including both univariate and bivariate hypothesis testing;
3. Uses of computers for data management and analyses; and
4. Ethical and legal considerations in research.

(10) Professional orientation. Studies that provide an understanding of all aspects of professional functioning, including history, roles, organizational structures, ethics, standards, and credentialing. Studies in this area include, but are not limited to, the following:

1. History of the helping professions, including significant factors and events;
2. Professional roles and functions, including similarities with and differences from other types of professionals;
3. Professional organizations (primarily ACA, its divisions, and its branches), including membership benefits, activities, services to members, and current emphases;
4. Ethical standards of the ACA and their evolution, legal issues, and applications to various professional activities (e.g., appraisal and group work);
5. Professional preparation standards and their evolution and current applications; and
6. Professional credentialing, including certification, licensure, and accreditation practices and standards, and the effects of public policy on these issues.

(11) Supervised counseling internship that provides an opportunity for the trainee to perform under supervision a variety of activities that a regularly employed staff member in a setting would be expected to perform. A regularly employed staff member is defined as a person occupying the professional

role to which the trainee is aspiring. The internship follows a supervised practicum experience. A three-semester-hour internship includes the following:

1. A minimum of 120 hours of direct service with clientele appropriate to the program of study;
2. A minimum of 1 hour per week of individual supervision, throughout the internship, usually performed by the on-site supervisor; and
3. A minimum of 1½ hours per week of group supervision, throughout the internship, usually performed by a program faculty member supervisor.

(12) Psychopathology. Studies that provide an understanding of the description, classification and diagnosis of behavior disorders and dysfunction. Studies in this area include, but are not limited to, the following:

1. Study of cognitive, behavioral, physiological and interpersonal mechanisms for adapting to change and to stressors;
2. Role of genetic, physiological, cognitive, environmental and interpersonal factors and their interactions on development of the form, severity, course and persistence of the various types of disorders and dysfunction;
3. Research methods and findings pertinent to the description, classification, diagnosis, origin, and course of disorders and dysfunction;
4. Theoretical perspectives relevant to the origin, development, and course and outcome for the forms of behavior disorders and dysfunction; and
5. Methods of intervention or prevention used to minimize and modify maladaptive behaviors, disruptive and distressful cognition, or compromised interpersonal functioning associated with various forms of maladaptation.

b. The degree of an applicant who entered a program of study on or after July 1, 2012, will be considered "content-equivalent" if the degree includes 60 semester hours (or equivalent quarter hours) and successful completion of graduate-level coursework in each of the areas in subparagraphs (1) to (12). If the applicant has taught a graduate-level course in any of the areas in subparagraphs (1) to (12) at a college or university accredited by an agency recognized by the United States Department of Education, that course may be credited toward the coursework requirement.

(1) Professional orientation and ethical practice. Studies that provide an understanding of all of the following aspects of professional functioning:

1. History and philosophy of the counseling profession, including mental health counseling;
2. Professional roles, functions, and relationships of the mental health counselor with other human services providers, including strategies for interagency/interorganization collaboration and communication;
3. Counselors' roles and responsibilities as members of an interdisciplinary emergency management response team during a local, regional, or national crisis, disaster or other trauma-causing event;
4. Self-care strategies appropriate to the counselor role;
5. Counseling supervision models, practices, and processes;
6. Professional organizations (i.e., primarily ACA, its divisions, branches, and affiliates), including membership benefits, activities, services to members, and current emphases;
7. Professional credentialing, including certification, licensure, and accreditation practices and standards, and the effects of public policy on these issues;
8. The role and process of the professional mental health counselor advocating on behalf of the profession;
9. Advocacy processes needed to address institutional and social barriers that impede access, equity, and success for clients; and
10. Ethical standards of ACA and related entities, and applications of ethical and legal considerations in professional counseling.

(2) Social and cultural diversity. Studies that provide an understanding of the cultural context of relationships, issues, and trends in a multicultural and diverse society including all of the following:

1. Multicultural and pluralistic trends, including characteristics and concerns within and among diverse groups nationally and internationally;

2. Attitudes, beliefs, understandings, and acculturative experiences, including specific experiential learning activities designed to foster students' understanding of self and culturally diverse clients;

3. Theories of multicultural counseling, identity development, and social justice;

4. Individual, couple, family, group, and community strategies for working with and advocating for diverse populations, including multicultural competencies;

5. Counselors' roles in developing cultural self-awareness, promoting cultural social justice, advocacy, and conflict resolution and other culturally supported behaviors that promote optimal wellness and growth of the human spirit, mind or body; and

6. Counselors' roles in eliminating biases, prejudices, and processes of intentional and unintentional oppression and discrimination.

(3) Human growth and development. Studies that provide an understanding of the nature and needs of persons at all developmental levels and in multicultural contexts, including all of the following:

1. Theories of individual and family development and transitions across the life span;

2. Theories of learning and personality development including current understandings about neurobiological behavior;

3. Effects of crises, disasters, and other trauma-causing events on persons of all ages;

4. Theories and models of individual, cultural, couple, family, and community resilience;

5. A general framework for understanding exceptional abilities and strategies for differentiated interventions;

6. Human behavior, including an understanding of developmental crises, disability, psychopathology, and situational and environmental factors that affect both normal and abnormal behavior;

7. Theories and etiology of addictions and addictive behaviors, including strategies for prevention, intervention, and treatment; and

8. Strategies for facilitating optimum development over the life span.

(4) Career development. Studies that provide an understanding of career development and related life factors, including all of the following:

1. Career development theories and decision-making models;

2. Career, avocational, educational, occupational and labor market information resources and career information systems;

3. Career development program planning, organization, implementation, administration, and evaluation;

4. Interrelationships among and between work, family, and other life roles and factors including the role of multicultural issues in career development;

5. Career and educational planning, placement, follow-up, and evaluation;

6. Assessment instruments and techniques relevant to career planning and decision making; and

7. Career counseling processes, techniques, and resources, including those applicable to specific populations.

(5) Helping relationships. Studies that provide an understanding of counseling processes in a multicultural society, including all of the following:

1. An orientation to wellness and prevention as desired counseling goals;

2. Counselor characteristics and behaviors that influence helping processes;

3. An understanding of essential interviewing and counseling skills;

4. Counseling theories that provide the student with a model(s) to conceptualize client presentation and select appropriate counseling interventions. Students shall be exposed to models of counseling that are consistent with current professional research and practice in the field so that they can begin to develop a personal model of counseling;

5. A systems perspective that provides an understanding of family and other systems theories and major models of family and related interventions;

6. A general framework for understanding and practicing consultation; and

7. Crisis intervention and suicide prevention models, including the use of psychological first-aid strategies.

(6) Group work. Studies that provide both theoretical and experiential understanding of group purpose, development, dynamics, theories, methods, skills, and other group approaches in a multicultural society, including all of the following:

1. Principles of group dynamics, including group process components, developmental stage theories, group members' roles and behaviors, and therapeutic factors of group work;

2. Group leadership or facilitation styles and approaches, including characteristics of various types of group leaders and leadership styles;

3. Theories of group counseling, including commonalties, distinguishing characteristics, and pertinent research and literature;

4. Group counseling methods, including group counselor orientations and behaviors, appropriate selection criteria and methods, and methods of evaluation of effectiveness; and

5. Experiences in which students participate as group members in a small group activity, approved by the program, for a minimum of 10 clock hours over the course of one academic term.

(7) Assessment. Studies that provide an understanding of individual and group approaches to assessment and evaluation in a multicultural society, including the following:

1. Historical perspectives concerning the nature and meaning of assessment;

2. Basic concepts of standardized and nonstandardized testing and other assessment techniques including norm-referenced and criterion-referenced assessment, environmental assessment, performance assessment, individual and group test and inventory methods, and behavioral observations;

3. Statistical concepts, including scales of measurement, measures of central tendency, indices of variability, shapes and types of distributions, and correlations;

4. Reliability (i.e., theory of measurement error, models of reliability, and the use of reliability information);

5. Validity (i.e., evidence of validity, types of validity, and the relationship between reliability and validity);

6. Social and cultural factors related to the assessment and evaluation of individuals, groups, and specific populations;

7. Ethical strategies for selecting, administering, and interpreting assessment and evaluation instruments and techniques in counseling; and

8. An understanding of general principles and methods of case conceptualization, assessment, or diagnoses of mental and emotional status.

(8) Research and program evaluation. Studies that provide an understanding of research methods, statistical analysis, needs assessment, and program evaluation, including all of the following:

1. The importance of research in advancing the counseling profession;

2. Research methods such as qualitative, quantitative, single-case designs, action research, and outcome-based research;

3. Statistical methods used in conducting research and program evaluation;

4. Principles, models, and applications of needs assessment, program evaluation, and use of findings to effect program modifications;

5. Use of research to inform evidence-based practice; and

6. Ethical and culturally relevant strategies for interpreting and reporting the results of research and program evaluation studies.

(9) Diagnosis and treatment planning. Studies that provide an understanding of individual and group approaches to assessment and evaluation in a multicultural society. Studies in this area include, but are not limited to, the following:

1. The principles of the diagnostic process, including differential diagnosis, and the use of current diagnostic tools, such as the current edition of the Diagnostic and Statistical Manual;

2. The established diagnostic criteria for mental or emotional disorders that describe treatment modalities and placement criteria within the continuum of care;

3. The impact of co-occurring substance use disorders on medical and psychological disorders;

4. The relevance and potential biases of commonly used diagnostic tools as related to multicultural populations;

5. The appropriate use of diagnostic tools, including the current edition of the Diagnostic and Statistical Manual, to describe the symptoms and clinical presentation of clients with mental or emotional impairments;

6. The ability to conceptualize accurate multi-axial diagnoses of disorders presented by clients and discuss the differential diagnosis with collaborating professionals; and

7. The ability to differentiate between diagnosis and developmentally appropriate reactions during crises, disasters, and other trauma-causing events.

(10) Psychopathology. Studies that provide an understanding of emotional and mental disorders experienced by persons of all ages, characteristics of disorders, and common nosologies of emotional and mental disorders utilized within the U.S. health care system for diagnosis and treatment planning. Studies in this area include, but are not limited to, the following:

1. Study of cognitive, behavioral, physiological and interpersonal mechanisms for adapting to change and to stressors;

2. Role of genetic, physiological, cognitive, environmental and interpersonal factors and their interactions on development of the form, severity, course and persistence of the various types of disorders and dysfunction;

3. Research methods and findings pertinent to the description, classification, diagnosis, origin, and course of disorders and dysfunction;

4. Theoretical perspectives relevant to the origin, development, and course and outcome for the forms of behavior disorders and dysfunction; and

5. Methods of intervention or prevention used to minimize and modify maladaptive behaviors, disruptive and distressful cognition, or compromised interpersonal functioning associated with various forms of maladaptation.

(11) Practicum. A graduate-level clinical supervised counseling practicum in a mental health setting in which students must complete supervised practicum experiences that total a minimum of 100 clock hours over a minimum ten-week academic term. The practicum provides for the development of counseling skills under supervision. The student's practicum includes all of the following:

1. At least 40 hours of direct service with actual clients that contributes to the development of counseling skills;

2. Weekly interaction with an average of 1 hour per week of individual or triadic supervision throughout the practicum by a program faculty member, a student supervisor, or a site supervisor who is working in biweekly consultation with a program faculty member in accordance with the supervision contract;

3. An average of 1½ hours per week of group supervision that is provided on a regular schedule throughout the practicum by a program faculty member or a student supervisor; and

4. Evaluation of the student's counseling performance throughout the practicum including documentation of a formal evaluation after the student completes the practicum.

(12) Internship. A graduate-level clinical supervised counseling internship in a mental health setting that requires students to complete a supervised internship of 600 clock hours that is begun after the student's successful completion of the practicum. The internship is intended to reflect the comprehensive work experience of a professional counselor appropriate to clinical mental health counseling. The internship provides an opportunity for the student to perform, under supervision, a variety of counseling activities that a mental health counselor is expected to perform. The student's internship includes all of the following:

1. At least 240 hours of direct service with clientele, including experience leading groups;

2. Weekly interaction that averages 1 hour per week of individual supervision or triadic supervision throughout the internship, usually performed by the on-site supervisor;

3. An average of 1½ hours per week of group supervision, provided on a regular schedule throughout the internship, usually performed by a program faculty member supervisor;

4. The opportunity for the student to become familiar with a variety of professional activities in addition to direct service (e.g., record keeping, supervision, information and referral, in-service and staff meetings);

5. The opportunity for the student to develop program-appropriate audio/video recordings for use in supervision or to receive live supervision of the student's interactions with clients;

6. The opportunity for the student to gain supervised experience in the use of a variety of professional resources such as assessment instruments, technologies, print and nonprint media, professional literature, and research; and

7. Evaluation of the student's counseling performance throughout the internship including documentation of a formal evaluation by a program faculty member in consultation with the site supervisor after the student completes the internship.

31.6(3) *Foreign-trained marital and family therapists or mental health counselors.* Foreign-trained marital and family therapists or mental health counselors shall:

a. Provide an equivalency evaluation of their educational credentials by the following: International Educational Research Foundations, Inc., Credentials Evaluation Service, P.O. Box 3665, Culver City, CA 90231-3665; telephone (310)258-9451; Web site www.ierf.org or E-mail at info@ierf.org. The professional curriculum must be equivalent to that stated in these rules. A candidate shall bear the expense of the curriculum evaluation.

b. Provide a notarized copy of the certificate or diploma awarded to the applicant from a mental health counselor program in the country in which the applicant was educated.

c. Receive a final determination from the board regarding the application for licensure.

[**ARC 7673B**, IAB 4/8/09, effective 4/30/09; **ARC 9547B**, IAB 6/1/11, effective 7/6/11; **ARC 1758C**, IAB 12/10/14, effective 1/14/15; **ARC 2845C**, IAB 12/7/16, effective 1/11/17]

645—31.7(154D) Clinical experience requirements for mental health counselors.

31.7(1) The supervised clinical experience shall:

a. Be a minimum of two years or the equivalent of full-time, postgraduate supervised professional work experience in mental health counseling.

b. Be completed following completion of the practicum, internship, and all graduate coursework, with the exception of the thesis.

c. Include successful completion of at least 3,000 hours of mental health counseling that shall include at least 1,500 hours of direct client contact and 200 hours of clinical supervision. Applicants who entered a program of study prior to July 1, 2010, shall include successful completion of 200 hours of clinical supervision concurrent with 1,000 hours of mental health counseling conducted in person with couples, families and individuals.

d. Include a minimum of 25 percent of all clinical supervision in person.

(1) The first two meetings shall be face-to-face and in person.

(2) Up to 50 percent of all supervision may be completed by telephone.

(3) Up to 75 percent of all supervision may be completed by electronic means.

(4) Supervision by electronic means is acceptable if the system utilized is a confidential, interactive, secure, real-time system that provides for visual and audio interaction between the licensee and the supervisor.

e. Include in the 200 hours of clinical supervision at least 100 hours of individual supervision.

f. Follow and maintain a plan throughout the supervisory period established by the supervisor and the licensee. Such a plan must be kept by the licensee for a period of five years following receipt of the permanent license and must be submitted to the board upon request. The plan for supervision shall include:

(1) The name, license number, date of licensure, address, telephone number, and e-mail address (when available) of the supervisor;

(2) The name, license number, address, telephone number, and e-mail address (when available) of supervisee;

(3) Employment setting in which experience will occur;

(4) The nature, duration and frequency of supervision;

(5) The number of hours of supervision per month;

(6) The supervisor/licensees type (individual/group) and mode (face-to-face/electronic) of supervision;

(7) The methodology for secure transmission of case information;

(8) The beginning date of supervised professional practice and estimated date of completion;

(9) The goals and objectives for the supervised professional practice; and

(10) The signatures of the supervisor and licensee, and the dates of signatures.

g. Have only supervised clinical contact credited for this requirement.

31.7(2) To meet the requirements of the supervised clinical experience:

a. The supervisee must:

(1) Meet with the supervisor a minimum of four hours per month;

(2) Offer documentation of supervised hours signed by the supervisor;

(3) Compute part-time employment on a prorated basis for the supervised professional experience;

(4) Have the background, training, and experience that are appropriate to the functions performed;

(5) Have supervision that is clearly distinguishable from personal counseling and is contracted in order to serve professional/vocational goals;

(6) Have individual supervision that shall be in person with no more than one supervisor to two supervisees;

(7) Have group supervision that may be completed with up to ten supervisees and a supervisor; and

(8) Not participate in the following activities which are deemed unacceptable for clinical supervision:

1. Peer supervision, i.e., supervision by a person of equivalent, but not superior, qualifications, status, and experience.

2. Supervision, by current or former family members, or any other person, in which the nature of the personal relationship prevents, or makes difficult, the establishment of a professional relationship.

3. Administrative supervision, e.g., clinical practice performed under administrative rather than clinical supervision of an institutional director or executive.

4. A primarily didactic process wherein techniques or procedures are taught in a group setting, classroom, workshop, or seminar.

5. Consultation, staff development, or orientation to a field or program, or role-playing of family interrelationships as a substitute for current clinical practice in an appropriate clinical situation.

b. The supervisor:

(1) May be a licensed mental health counselor in Iowa with at least three years of postlicensure clinical experience; or

(2) Shall be approved by the National Board for Certified Counselors (NBCC) as a supervisor; or

(3) May be an alternate supervisor who possesses qualifications equivalent to a licensed mental health counselor with at least three years of postlicensure clinical experience, including mental health professionals licensed to practice independently; and

(4) Shall meet a minimum of four hours per month with the supervisee; and

(5) Shall provide training that is appropriate to the functions to be performed; and

(6) Shall ensure that therapeutic work is done under the professional supervision of a supervisor; and

(7) Shall not supervise any mental health counselor or permit the supervisee to engage in any therapy which the supervisor cannot perform competently.

c. Effective October 1, 2020, the supervisor shall:

(1) Be an Iowa-licensed mental health counselor in Iowa with at least three years of clinical experience following licensure or shall be approved by the National Board for Certified Counselors (NBCC) as a supervisor; or

(2) Be an Iowa-licensed marital and family therapist with a minimum of three years of clinical experience following licensure or shall be a supervisor or supervisor candidate approved by the American Association for Marriage and Family Therapy Commission on Supervision; and

(3) Have completed at least a six-hour continuing education course in counseling supervision or one master's level course in counseling supervision; and

(4) Meet a minimum of four hours per month with the supervisee; and

(5) Provide training that is appropriate to the functions to be performed; and

(6) Ensure that therapeutic work is completed under the professional supervision of a supervisor; and

(7) Not supervise any mental health counselor or permit the supervisee to engage in any therapy that the supervisor cannot perform competently.

d. Exceptions to paragraph 31.7(2)*"c"* shall be made on an individual basis. Requests for alternative supervisors must be submitted in writing, and the board must approve the supervisor prior to commencement of the supervision.

31.7(3) Rescinded IAB 7/6/05, effective 8/10/05.

31.7(4) An applicant who has obtained Certified Clinical Mental Health Counselor status with the National Board for Certified Counselors (NBCC) is considered to have met the clinical experience requirements of rule 645—31.7(154D). The applicant shall ensure that proof of current certified clinical mental health counselor status be sent directly from NBCC to the board.

[**ARC 7673B**, IAB 4/8/09, effective 4/30/09; **ARC 8152B**, IAB 9/23/09, effective 10/28/09; **ARC 9547B**, IAB 6/1/11, effective 7/6/11; **ARC 0777C**, IAB 6/12/13, effective 7/17/13; **ARC 2845C**, IAB 12/7/16, effective 1/11/17]

645—31.8(154D) Licensure by endorsement. An applicant who has been a licensed marriage and family therapist or mental health counselor under the laws of another jurisdiction may file an application for licensure by endorsement with the board office.

31.8(1) The board may receive by endorsement any applicant from the District of Columbia or another state, territory, province or foreign country who:

a. Submits to the board a completed application;

b. Pays the licensure fee;

c. Shows evidence of licensure requirements that are similar to those required in Iowa;

d. Provides official transcripts sent directly from the school to the board verifying completion of a master's degree of 45 hours or equivalent if the applicant entered a program of study prior to July 1, 2012, or verifying completion of a master's degree of 60 hours or equivalent if the applicant entered a program of study on or after July 1, 2012, or the appropriate doctoral degree. Graduates from a non-CACREP-accredited mental health counselor program or a non-COAMFTE-accredited marital and family therapy program shall provide an equivalency evaluation of their educational credentials by the Center for Credentialing and Education, Inc. (CCE), Web site http://cce-global.org. The professional curriculum must be equivalent to that stated in these rules. Applicants shall bear the expense of the curriculum evaluation;

e. Supplies satisfactory evidence of the candidate's qualifications in writing on the prescribed forms by the candidate's supervisors. If verification of clinical experience is not available, the board may consider submission of documentation from the state in which the applicant is currently licensed or equivalent documentation of supervision;

f. Provides verification(s) of license(s) from every jurisdiction in which the applicant has been licensed, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification direct from the jurisdiction's board office if the verification provides:

(1) Licensee's name;

(2) Date of initial licensure;

(3) Current licensure status; and

(4) Any disciplinary action taken against the license; and

g. Has the examination score sent directly from the testing service to the board.

31.8(2) In lieu of meeting the requirements of paragraphs 31.8(1)*"d"* and *"e,"* applicants who meet the qualifications below may instead submit documentation demonstrating how each of the qualifications below is satisfied:

a. The applicant has been licensed as a mental health counselor or a marital and family therapist in another state for at least five years at the independent level (independent level means the highest level of licensure in the field offered by the particular state);

b. The applicant has been practicing under the independent license in a clinical mental health or marital and family therapy counseling setting for at least five years;

c. The applicant possesses a master's degree or higher in mental health counseling or marital and family therapy or an equivalent counseling-related field; and

d. The applicant does not have any past or pending disciplinary action from any state licensing boards related to any mental health counseling or marital and family therapy license currently or previously held by the applicant.

[**ARC 7673B**, IAB 4/8/09, effective 4/30/09; **ARC 0777C**, IAB 6/12/13, effective 7/17/13; **ARC 1758C**, IAB 12/10/14, effective 1/14/15; **ARC 2845C**, IAB 12/7/16, effective 1/11/17]

645—31.9(147) Licensure by reciprocal agreement. Rescinded IAB 1/14/09, effective 2/18/09.

645—31.10(147) License renewal.

31.10(1) The biennial license renewal period for a license to practice marital and family therapy or mental health counseling shall begin on October 1 of an even-numbered year and end on September 30 of the next even-numbered year. The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive notice from the board does not relieve the licensee of the responsibility for renewing the license.

31.10(2) An individual who was issued an initial license within six months of the license renewal date will not be required to renew the license until the subsequent renewal two years later.

31.10(3) A licensee seeking renewal shall:

a. Meet the continuing education requirements of rule 645—32.2(272C) and the mandatory reporting requirements of subrule 31.10(4). A licensee whose license was reactivated during the current renewal compliance period may use continuing education credit earned during the compliance period for the first renewal following reactivation; and

b. Submit the completed renewal application and renewal fee before the license expiration date.

c. An individual who was issued a license within six months of the license renewal date will not be required to renew the license until the next renewal two years later.

31.10(4) Mandatory reporter training requirements.

a. A licensee who, in the scope of professional practice or in the licensee's employment responsibilities, examines, attends, counsels or treats children in Iowa shall indicate on the renewal application completion of two hours of training in child abuse identification and reporting in the previous five years or condition(s) for waiver of this requirement as identified in paragraph *"e."*

b. A licensee who, in the course of employment, examines, attends, counsels or treats adults in Iowa shall indicate on the renewal application completion of two hours of training in dependent adult abuse identification and reporting in the previous five years or condition(s) for waiver of this requirement as identified in paragraph *"e."*

c. A licensee who, in the scope of professional practice or in the course of employment, examines, attends, counsels or treats both adults and children in Iowa shall indicate on the renewal application completion of training in abuse identification and reporting for dependent adults and children in the previous five years or condition(s) for waiver of this requirement as identified in paragraph *"e."*

Training may be completed through separate courses as identified in paragraphs *"a"* and *"b"* or in one combined two-hour course that includes curricula for identifying and reporting child abuse and dependent adult abuse. The course shall be a curriculum approved by the Iowa department of public health abuse education review panel.

d. The licensee shall maintain written documentation for five years after mandatory training as identified in paragraphs *"a"* to *"c,"* including program date(s), content, duration, and proof of participation.

e. The requirement for mandatory training for identifying and reporting child and dependent adult abuse shall be suspended if the board determines that suspension is in the public interest or that a person at the time of license renewal:

(1) Is engaged in active duty in the military service of this state or the United States.

(2) Holds a current waiver by the board based on evidence of significant hardship in complying with training requirements, including an exemption of continuing education requirements or extension of time in which to fulfill requirements due to a physical or mental disability or illness as identified in 645—Chapter 4.

f. The board may select licensees for audit of compliance with the requirements in paragraphs *"a"* to *"e."*

31.10(5) Upon receiving the information required by this rule and the required fee, board staff shall administratively issue a two-year license and shall send the licensee a wallet card by regular mail. In the event the board receives adverse information on the renewal application, the board shall issue the renewal license but may refer the adverse information for further consideration or disciplinary investigation.

31.10(6) A person licensed to practice as a marital and family therapist or mental health counselor shall keep the person's license certificate and wallet card displayed in a conspicuous public place at the primary site of practice.

31.10(7) Late renewal. The license shall become late when the license has not been renewed by the expiration date on the wallet card. The licensee shall be assessed a late fee as specified in 645—subrule 5.3(3). To renew a late license, the licensee shall complete the renewal requirements and submit the late fee within the grace period.

31.10(8) Inactive license. A licensee who fails to renew the license by the end of the grace period has an inactive license. A licensee whose license is inactive continues to hold the privilege of licensure in Iowa, but may not practice mental health counseling or marital and family therapy in Iowa until the license is reactivated. A licensee who practices mental health counseling or marital and family therapy in the state of Iowa with an inactive license may be subject to disciplinary action by the board, injunctive action pursuant to Iowa Code section 147.83, criminal sanctions pursuant to Iowa Code section 147.86, and other available legal remedies.

[**ARC 9547B**, IAB 6/1/11, effective 7/6/11]

645—31.11(272C) Exemptions for inactive practitioners. Rescinded IAB 7/6/05, effective 8/10/05.

645—31.12(147) Licensee record keeping.

31.12(1) A licensee shall maintain sufficient, timely, and accurate documentation in client records.

31.12(2) For purposes of this rule, "client" means the individual, couple, family, or group to whom a licensee provides direct clinical services.

31.12(3) A licensee's records shall reflect the services provided, facilitate the delivery of services, and ensure continuity of services in the future.

31.12(4) Clinical services. A licensee who provides clinical services in any employment setting, including private practice, shall:

a. Store records in accordance with state and federal statutes and regulations governing record retention and with the guidelines of the licensee's employer or agency, if applicable. If no other legal provisions govern record retention, a licensee shall store all client records for a minimum of seven years after the date of the client's discharge or death, or, in the case of a minor, for three years after the client reaches the age of majority under state law or seven years after the date of the client's discharge or death, whichever is longer.

b. Maintain timely records that include subjective and objective data, an assessment, a treatment plan, and any revisions to the assessment or plan made during the course of treatment.

c. Provide the client with reasonable access to records concerning the client. A licensee who is concerned that a client's access to the client's records could cause serious misunderstanding or harm to the client shall provide assistance in interpreting the records and consultation with the client regarding the records. A licensee may limit a client's access to the client's records, or portions of the records, only

in exceptional circumstances when there is compelling evidence that such access would cause serious harm to the client. Both the client's request for access and the licensee's rationale for withholding some or all of a record shall be documented in the client's records.

d. Take steps to protect the confidentiality of other individuals identified or discussed in any records to which a client is provided access.

31.12(5) Electronic record keeping. The requirements of this rule apply to electronic records as well as to records kept by any other means. When electronic records are kept, the licensee shall ensure that a duplicate hard-copy record or a backup, unalterable electronic record is maintained.

31.12(6) Correction of records.

a. Hard-copy records. Original notations shall be legible, written in ink, and contain no erasures or whiteouts. If incorrect information is placed in the original record, it must be crossed out with a single, nondeleting line and be initialed and dated by the licensee.

b. Electronic records. If a record is stored in an electronic format, the record may be amended with a signed addendum attached to the record.

31.12(7) Confidentiality and transfer of records. Marital and family therapists or mental health counselors shall preserve the confidentiality of client records in accordance with their respective rules of conduct and with federal and state law. Upon receipt of a written release or authorization signed by the client, the licensee shall furnish such therapy records, or copies of the records, as will be beneficial for the future treatment of that client. A fee may be charged for duplication of records, but a licensee may not refuse to transfer records for nonpayment of any fees. A written request may be required before transferring the record(s).

31.12(8) Retirement, death or discontinuance of practice.

a. If a licensee is retiring or discontinuing practice and is the owner of a practice, the licensee shall notify in writing all active clients and, upon knowledge and agreement of the clients, shall make reasonable arrangements with those clients to transfer client records, or copies of those records, to the succeeding licensee.

b. Upon a licensee's death:

(1) The licensee's employer or representative must ensure that all client records are transferred to another licensee or entity that is held to the same standards of confidentiality and agrees to act as custodian of the records.

(2) The licensee's employer or representative shall notify each active client that the client's records will be transferred to another licensee or entity that will retain custody of the records and that, at the client's written request, the records will be sent to the licensee or entity of the client's choice.

31.12(9) Nothing stated in this rule shall prohibit a licensee from conveying or transferring the licensee's client records to another licensed individual who is assuming a practice, provided that written notice is furnished to all clients.

645—31.13(147) Duplicate certificate or wallet card. Rescinded IAB 1/14/09, effective 2/18/09.

645—31.14(147) Reissued certificate or wallet card. Rescinded IAB 1/14/09, effective 2/18/09.

645—31.15(17A,147,272C) License denial. Rescinded IAB 1/14/09, effective 2/18/09.

645—31.16(17A,147,272C) License reactivation. To apply for reactivation of an inactive license, a licensee shall:

31.16(1) Submit a reactivation application on a form provided by the board.

31.16(2) Pay the reactivation fee that is due as specified in 645—Chapter 5.

31.16(3) Provide verification of current competence to practice mental health counseling or marital and family therapy by satisfying one of the following criteria:

a. If the license has been on inactive status for five years or less, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction's board office if the verification includes:

1. Licensee's name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 40 hours of continuing education obtained within the two years immediately preceding the application for reactivation.

b. If the license has been on inactive status for more than five years, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction's board office if the verification includes:

1. Licensee's name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 80 hours of continuing education obtained within the two years immediately preceding the application for reactivation.

[**ARC 0777C**, IAB 6/12/13, effective 7/17/13]

645—31.17(17A,147,272C) License reinstatement. A licensee whose license has been revoked, suspended, or voluntarily surrendered must apply for and receive reinstatement of the license in accordance with 645—11.31(272C) and must apply for and be granted reactivation of the license in accordance with 645—31.16(17A,147,272C) prior to practicing mental health counseling or marital and family therapy in this state.

645—31.18(154D) Marital and family therapy and mental health counselor services subject to regulation. Marital and family therapy and mental health counselor services provided to an individual in this state through telephonic, electronic or other means, regardless of the location of the marital and family therapy and mental health counselor, shall constitute the practice of marital and family therapy and mental health counseling and shall be subject to regulation in Iowa.

These rules are intended to implement Iowa Code chapters 17A, 147, 154D and 272C.

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◊ Two or more ARCs

1 February 18, 2009, effective date of amendments to 645—31.4(154D) to 645—31.8(154D), **ARC 7476B**, Items 5 to 9, delayed 70 days by the Administrative Rules Review Committee at its meeting held February 6, 2009.

CHAPTER 32
CONTINUING EDUCATION FOR MARITAL AND FAMILY THERAPISTS AND MENTAL HEALTH COUNSELORS

645—32.1(272C) Definitions. For the purpose of these rules, the following definitions shall apply:

"Active license" means the license is current and has not expired.

"Approved program/activity" means a continuing education program/activity meeting the standards set forth in these rules.

"Audit" means the selection of licensees for verification of satisfactory completion of continuing education requirements during a specified time period.

"Board" means the board of behavioral science.

"Continuing education" means planned, organized learning acts designed to maintain, improve, or expand a licensee's knowledge and skills in order for the licensee to develop new knowledge and skills relevant to the enhancement of practice, education, or theory development to improve the safety and welfare of the public.

"Hour of continuing education" means at least 50 minutes spent by a licensee in actual attendance at and completion of approved continuing education activity.

"Inactive license" means a license that has expired because it was not renewed by the end of the grace period. The category of "inactive license" may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

"License" means license to practice.

"Licensee" means any person licensed to practice marital and family therapy or mental health counseling in the state of Iowa.

645—32.2(272C) Continuing education requirements.

32.2(1) The biennial continuing education compliance period shall extend for a two-year period beginning on October 1 of the even-numbered year and ending on September 30 of the next even-numbered year. Each biennium, each person who is licensed to practice as a licensee in this state shall be required to complete a minimum of 40 hours of continuing education approved by the board.

32.2(2) Requirements of new licensees. Those persons licensed for the first time shall not be required to complete continuing education as a prerequisite for the first renewal of their licenses. Continuing education hours acquired anytime from the initial licensing until the second license renewal may be used. The new licensee will be required to complete a minimum of 40 hours of continuing education per biennium for each subsequent license renewal.

32.2(3) Hours of continuing education credit may be obtained by attending and participating in a continuing education activity. These hours must be in accordance with these rules.

32.2(4) No hours of continuing education shall be carried over into the next biennium except as stated for the second renewal. A licensee whose license was reactivated during the current renewal compliance period may use continuing education earned during the compliance period for the first renewal following reactivation.

32.2(5) It is the responsibility of each licensee to finance the cost of continuing education.

645—32.3(154D,272C) Standards.

32.3(1) *General criteria.* A continuing education activity which meets all of the following criteria is appropriate for continuing education credit if the continuing education activity:

a. Constitutes an organized program of learning which contributes directly to the professional competency of the licensee;

b. Pertains to subject matters which integrally relate to the practice of the profession;

c. Is conducted by individuals who have specialized education, training and experience by reason of which said individuals should be considered qualified concerning the subject matter of the program. At the time of audit, the board may request the qualifications of presenters.

d. Fulfills stated program goals, objectives, or both; and

e. Provides proof of attendance to licensees in attendance including:

(1) Date(s), location, course title, presenter(s);

(2) Number of program contact hours; and

(3) Certificate of completion or evidence of successful completion of the course provided by the course sponsor.

32.3(2) *Specific criteria.* Continuing education hours of credit may be obtained by completing the following:

a. Attendance at workshops, conferences, symposiums and academic courses. Official transcripts indicating successful completion of academic courses which apply to the field of mental health counseling or marital and family therapy, as appropriate, will be necessary in order to receive the following continuing education credits:

1 academic semester hour = 15 continuing education hours

1 academic quarter hour = 10 continuing education hours

b. Rescinded IAB 7/6/05, effective 8/10/05.

c. A maximum of 20 hours of continuing education credit may be granted for any of the following activities not to exceed a combined total of 20 hours:

(1) Presenting professional programs which meet the criteria in 645—32.3(272C). Two hours of credit will be awarded for each hour of presentation. A course schedule or brochure must be maintained for audit. Presentation at a professional program does not include teaching class at an institution of higher learning at which the applicant is regularly and primarily employed. Presentations to lay public are excluded.

(2) Scholarly research or other activities, the results of which are published in a recognized professional publication such as a refereed journal, monograph or conference proceedings. The scholarly research must be integrally related to the practice of the professions.

(3) Publication in a refereed journal. The article in a refereed journal for which the licensee is seeking continuing education credit must be integrally related to the practice of the professions.

(4) Distance learning conferences or courses will be allowed if the following criteria are met:

1. The program is offered through electronic transmission.

2. The program allows for interaction between the presenter and the participants.

3. The program issues the participants an official transcript, certificate of attendance or verification of successful completion of the course which applies to the field of mental health counseling or marital and family therapy.

(5) Home study courses will be allowed if the following criteria are met:

1. The program is recognized by the National Board for Certified Counselors (NBCC) or American Association of Marriage and Family Therapy (AAMFT) or meets all of the criteria in 645—32.3(272C).

2. An official transcript, verification or certificate of completion is presented after successful completion of the course.

(6) Viewing multimedia presentations will be allowed if the following criteria are met:

1. There is a sponsoring group or agency.

2. There is a facilitator or program official present.

3. The program official may not be the only attendee.

4. The program meets all of the criteria in 645—32.3(272C).

(7) Computer-assisted instructional courses or programs pertaining to the practice of mental health counseling or marital and family therapy will be allowed if the following criteria are met:

1. The courses and programs are approved by the National Board for Certified Counselors (NBCC) or American Association of Marriage and Family Therapy (AAMFT) or their affiliates or meet all of the criteria in 645—32.3(272C).

2. An official transcript, certificate of completion, or verification that includes the following information is presented after successful completion of the course:

- Date course/program was completed.
- Title of the course/program.
- Number of course/program continuing education hours.

- Official signature or verification of the course/program sponsor.

(8) Teaching in an approved college, university, or graduate school. The licensee may receive credit on a one-time basis for the first offering of the course.

(9) Authoring papers, publications, and books. The licensee shall receive five hours of credit per page with a maximum of 20 hours of credit.

32.3(3) *Required specific criteria:*

a. Three hours of the 40 continuing education hours shall be in ethics.

b. Effective with the biennial continuing education compliance period that begins October 1, 2022, persons serving in a supervisory role must complete three hours of continuing education in supervision.
[**ARC 2845C**, IAB 12/7/16, effective 1/11/17]

645—32.4(154D,272C) Audit of continuing education report. Rescinded IAB 6/1/11, effective 7/6/11.

645—32.5(154D,272C) Automatic exemption. Rescinded IAB 1/14/09, effective 2/18/09.

645—32.6(154D,272C) Grounds for disciplinary action. Rescinded IAB 1/14/09, effective 2/18/09.

645—32.7(272C) Continuing education waiver for active practitioners. Rescinded IAB 7/6/05, effective 8/10/05.

645—32.8(272C) Continuing education exemption for inactive practitioners. Rescinded IAB 7/6/05, effective 8/10/05.

645—32.9(154D,272C) Continuing education exemption for disability or illness. Rescinded IAB 1/14/09, effective 2/18/09.

645—32.10(272C) Reinstatement of inactive practitioners. Rescinded IAB 7/6/05, effective 8/10/05.

645—32.11(272C) Hearings. Rescinded IAB 7/6/05, effective 8/10/05.

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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]

CHAPTER 1
PURPOSE AND ORGANIZATION

CHAPTER 2
PHARMACIST LICENSES

CHAPTER 3
PHARMACY TECHNICIANS

CHAPTER 6
GENERAL PHARMACY PRACTICE

CHAPTER 7
HOSPITAL PHARMACY PRACTICE

CHAPTER 8
UNIVERSAL PRACTICE STANDARDS

CHAPTER 11
DRUGS IN EMERGENCY MEDICAL SERVICE PROGRAMS

CHAPTER 20
COMPOUNDING PRACTICES

CHAPTER 21
ELECTRONIC DATA IN PHARMACY PRACTICE

CHAPTER 22
UNIT DOSE, ALTERNATIVE PACKAGING, AND EMERGENCY BOXES

CHAPTER 23
LONG-TERM CARE PHARMACY PRACTICE

CHAPTER 24
PHARMACY INTERNET SITES

CHAPTER 25
CHILD SUPPORT NONCOMPLIANCE

CHAPTER 26
PETITIONS FOR RULE MAKING
(Uniform Rules)

CHAPTER 27
DECLARATORY ORDERS
(Uniform Rules)

CHAPTER 28
AGENCY PROCEDURE FOR RULE MAKING
(Uniform Rules)

CHAPTER 29
SALES OF GOODS AND SERVICES

CHAPTER 30
IOWA MONITORING PROGRAM FOR PHARMACY PROFESSIONALS

CHAPTER 31
STUDENT LOAN DEFAULT OR NONCOMPLIANCE
WITH AGREEMENT FOR PAYMENT OF OBLIGATION

CHAPTER 32
NONPAYMENT OF STATE DEBT

CHAPTER 33
MILITARY SERVICE AND VETERAN RECIPROCITY

CHAPTER 34
RULES FOR WAIVERS AND VARIANCES

CHAPTER 35
CONTESTED CASES

CHAPTER 36
DISCIPLINE

CHAPTER 30
IOWA MONITORING PROGRAM FOR PHARMACY PROFESSIONALS

657—30.1(272C) Iowa monitoring program for pharmacy professionals committee. Pursuant to the authority of Iowa Code section 272C.3(1)*"k,"* the board establishes the committee for the Iowa monitoring program for pharmacy professionals. The purpose of the committee is to provide a program to support the evaluation and monitoring of licensees who are impaired as a result of alcohol or drug abuse, dependency, or addiction, or by any mental or physical disorder or disability, while protecting the health, safety and welfare of the public.
[**ARC 2834C**, IAB 12/7/16, effective 1/11/17]

657—30.2(272C) Definitions. For purposes of these rules, the following definitions shall apply:

"Board" means the Iowa board of pharmacy.

"Committee" means the Iowa monitoring program for pharmacy professionals committee.

"Contract" means the written document executed by an applicant or licensee and the committee after the committee receives a report from an approved treatment provider, which establishes the terms for participation in the program.

"Impairment" means an inability, or significant potential for inability, to practice with reasonable safety and skill as a result of a diagnosed substance use disorder or any diagnosed mental or physical health condition.

"Initial agreement" means the written document establishing the initial terms for participation in the program.

"Licensee" means a pharmacist licensed by the board, a pharmacist-intern registered with the board, or a pharmacy technician registered with the board.

"Participant" means an applicant or licensee who does any of the following: self-reports an impairment to the program, is referred to the program by the board, signs an initial agreement with the committee, or signs a contract with the committee.

"Program" means the Iowa monitoring program for pharmacy professionals.

"Self-report" means that an applicant or licensee provides written notification to the program that the applicant or licensee has been, is, or may be impaired. Information related to impairment or a potential impairment which is provided on a license application or renewal form may be considered a self-report.
[**ARC 2834C**, IAB 12/7/16, effective 1/11/17]

657—30.3(272C) Organization of the committee. The board shall appoint the members of the Iowa monitoring program for pharmacy professionals committee.

30.3(1) *Membership.* The membership of the committee includes, but is not limited to:

a. The executive director of the board or the director's designee from board staff;

b. One representative from the Drake University College of Pharmacy and Health Sciences;

c. One representative from the University of Iowa College of Pharmacy;

d. One board of pharmacy licensee who has maintained sobriety for a period of no less than two years following successful completion of a recovery program;

e. One health care professional with expertise in substance use disorders;

f. One health care professional with expertise in mental health; and

g. One public member.

30.3(2) *Officers.* At the last meeting of each calendar year, the committee shall elect a chairperson and a vice chairperson, each of whom will begin serving a one-year term on January 1.

a. The chairperson is responsible for offering guidance and direction to staff between regularly scheduled committee meetings, including guidance and direction concerning program descriptions, interim restrictions on practice, and negotiation and execution of initial agreements and contracts on behalf of the committee. The committee retains authority to review all interim decisions at its discretion.

b. The vice chairperson is responsible for providing guidance and direction to staff between regularly scheduled committee meetings if the chairperson is unavailable or unable to assist in a particular matter.

30.3(3) *Terms.* Committee members, except the executive director or designee, shall be appointed for three-year terms and shall serve for a maximum of three terms. Each term shall expire on December 31 of the third year of the term.
[**ARC 2834C**, IAB 12/7/16, effective 1/11/17]

657—30.4(272C) Eligibility.

30.4(1) *Self-report.* An applicant or a licensee shall self-report an impairment or potential impairment directly to the program.

30.4(2) *Board referral.* The board may refer an applicant or licensee to the program if a complaint or investigation reveals an impairment or potential impairment and the board determines that the applicant or licensee is an appropriate candidate for review by the committee. The board may refer a licensee to the program in a public disciplinary order or other public order.

30.4(3) *Review by the committee.* The committee will determine on a case-by-case basis whether an applicant or licensee who self-reports or is referred by the board is an appropriate candidate for participation in the program. Several factors may lead to the committee's determination that an applicant or licensee is ineligible to participate in the program, including but not limited to if the committee finds sufficient evidence that the applicant or licensee:

a. Diverted drugs for distribution to third parties or for personal profit;

b. Adulterated, misbranded, or otherwise tampered with drugs intended for a patient;

c. Provided inaccurate, misleading, or fraudulent information or failed to fully cooperate with the committee;

d. Participated in the program, or a similar program offered by another state, without success; or

e. Failed to sign an initial agreement or a contract when offered by the committee.

30.4(4) *Discretion.* Eligibility of a person to participate in the program is at the sole discretion of the committee. No person is entitled to participate in the program.

30.4(5) *Authority and jurisdiction.* Participation in the program does not divest the board of its authority or jurisdiction over the participant. A participant with an impairment or potential impairment may be eligible to participate in the program while being subject to investigation or discipline by the board for matters other than the alleged impairment.
[**ARC 2834C**, IAB 12/7/16, effective 1/11/17]

657—30.5(272C) Terms of participation. A participant shall agree to comply with the program terms of participation established in the initial agreement and the contract. Participants will be responsible for all expenses incurred to comply with the terms imposed by the program. Terms of participation specified in the contract shall include, but not be limited to:

30.5(1) *Duration.* The length of time a participant may participate in the program shall be determined by the committee in accordance with the following:

a. Participation in the program for participants impaired as a result of a substance use disorder is set at a minimum of three years. The committee may offer a contract with a shorter duration to a participant who can demonstrate successful participation in another state's monitoring program, who can document similar experience, or who, as a board referral, has successfully completed a portion of the monitoring period established in the board order.

b. Length of participation in the program for participants with impairments resulting from mental or physical conditions will vary depending upon the recommendations provided by health care providers and the determination of the committee following review of all relevant information.

30.5(2) *Requirements.* The committee shall establish terms of participation designed to meet the specific needs of a participant. The committee shall determine the type of recovery, rehabilitation, or maintenance program required to treat the participant's impairment. The contract shall provide a detailed description of the goals of the program, the requirements for successful participation, and the participant's obligations therein. The committee may establish terms of participation specific to a participant's impairment including, but not limited to, the following: treatment, aftercare, worksite monitoring, chemical screening, further evaluations, structured recovery meetings, therapy, and medication management.

30.5(3) *Practice restrictions.* The committee may impose restrictions on the license to practice as a term of the initial agreement or contract until such time as the committee receives a report from an approved evaluator, and the committee determines, based on all relevant information, that the participant is capable of practicing with reasonable skill and safety. As a condition of participation in the program, a licensee is required to agree to restricted practice in accordance with the terms specified in the initial agreement or contract. In the event the licensee refuses to agree to or comply with the practice restrictions, the committee shall refer the licensee to the board for appropriate action.

30.5(4) *Noncompliance.* Noncompliance is the failure to adhere to the terms of the initial agreement or contract. Participants shall promptly notify the committee of any instances of noncompliance, including relapse. Any instances of significant noncompliance shall be reported by the committee to the board. The report shall include a description of the noncompliance and the committee's recommendation as to whether the participant should remain in the program.

[**ARC 2834C**, IAB 12/7/16, effective 1/11/17]

657—30.6(272C) Confidentiality. Information in the possession of the board or the committee shall be subject to the confidentiality requirements of Iowa Code section 272C.6. Information about participants in the program shall not be disclosed except as provided in this rule.

30.6(1) The committee is authorized, pursuant to Iowa Code section 272C.6(4), to communicate information about a current or former program participant to the applicable regulatory authorities or licensee monitoring programs in the state of Iowa and in any jurisdiction of the United States or foreign nations in which the participant is currently licensed or in which the participant seeks licensure. Program participants must report their participation to the applicable monitoring program or licensing authority in any state in which the participant is currently licensed or in which the participant seeks licensure.

30.6(2) The committee is authorized to communicate information about a program participant to any person assisting in the participant's treatment, recovery, rehabilitation, monitoring, or maintenance for the duration of the contract.

30.6(3) The committee is authorized to communicate information about a program participant to the board in the event a participant does not comply with the terms of the contract as set forth in rule 657—30.5(272C). The committee may provide the board with a participant's program file in the event the participant does not comply with the terms of the contract and the committee refers the case to the board for the filing of formal disciplinary charges or other appropriate action. If the board initiates disciplinary action against a licensee for noncompliance with the terms of the contract, the board may include in the public disciplinary documents information about a licensee's participation in the program. The committee is also authorized to communicate information about a participant to the board in the event that the participant is under investigation by the board.

30.6(4) The committee is authorized to communicate information about a current or former program participant to the board if reliable information held by the committee reasonably indicates that a significant risk to the public exists. If the board initiates disciplinary action based upon this information, the board may include in the public disciplinary documents information about a licensee's participation if necessary to address impairment issues related to the violations which are the subject of the disciplinary action.

[**ARC 2834C**, IAB 12/7/16, effective 1/11/17]

657—30.7(28E) Authority for 28E agreements. The committee may enter into 28E agreements with other health professional licensing boards to evaluate, assist, and monitor impaired licensees from other health professions who self-report and to report to those professional licensing boards regarding the compliance of individual licensees. In the event of noncompliance, the licensee may be referred to the appropriate licensing board for appropriate disciplinary action.

[**ARC 2834C**, IAB 12/7/16, effective 1/11/17]

These rules are intended to implement Iowa Code section 272C.3(1)*"k."*

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REVENUE DEPARTMENT[701]

Created by 1986 Iowa Acts, chapter 1245.

CHAPTERS 1 and 2
Reserved

CHAPTER 3
VOLUNTARY DISCLOSURE PROGRAM

CHAPTER 4
MULTILEVEL MARKETER AGREEMENTS

CHAPTER 5
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES
(Uniform Rules)

TITLE I
ADMINISTRATION

CHAPTER 6
ORGANIZATION, PUBLIC INSPECTION

CHAPTER 7
PRACTICE AND PROCEDURE BEFORE THE DEPARTMENT OF REVENUE

CHAPTER 10
INTEREST, PENALTY, EXCEPTIONS TO PENALTY, AND JEOPARDY ASSESSMENTS

ALL TAXES

10.115(421) Application of payments to penalty, interest, and then tax due for payments made on or after January 1, 1995, unless otherwise designated by the taxpayer

JEOPARDY ASSESSMENTS

10.116(422,453B) Jeopardy assessments
10.117(422,453B) Procedure for posting bond
10.118(422,453B) Time limits
10.119(422,453B) Amount of bond
10.120(422,453B) Posting of bond
10.121(422,453B) Order
10.122(422,453B) Director's order
10.123(422,453B) Type of bond
10.124(422,453B) Form of surety bond
10.125(422,453B) Duration of the bond
10.126(422,453B) Exoneration of the bond

TITLE II
EXCISE

CHAPTER 11
ADMINISTRATION

11.1(422,423) Definitions
11.2(422,423) Statute of limitations
11.3(422,423) Credentials and receipts
11.4(422,423) Retailers required to keep records
11.5(422,423) Audit of records
11.6(422,423) Billings
11.7(422,423) Collections
11.8(422,423) No property exempt from distress and sale
11.9(422,423) Information confidential
11.10(423) Bonding procedure

CHAPTER 12
FILING RETURNS, PAYMENT OF TAX, PENALTY AND INTEREST

12.1(422) Returns and payment of tax
12.2(422,423) Remittances
12.3(422) Permits and negotiated rate agreements
12.4(422) Nonpermit holders
12.5(422,423) Regular permit holders responsible for collection of tax
12.6(422,423) Sale of business
12.7(422) Bankruptcy, insolvency or assignment for benefit of creditors
12.8(422) Vending machines and other coin-operated devices
12.9(422) Claim for refund of tax
12.10(423) Audit limitation for certain services
12.11 Reserved
12.12(422) Extension of time for filing
12.13(422) Determination of filing status
12.14(422,423) Immediate successor liability for unpaid tax
12.15(422,423) Officers and partners—personal liability for unpaid tax
12.16(422) Show sponsor liability
12.17(422) Purchaser liability for unpaid sales tax
12.18(423) Biodiesel production refund
12.19(15) Sales and use tax refund for eligible businesses

CHAPTER 13
PERMITS

CHAPTER 14
COMPUTATION OF TAX

CHAPTER 15
DETERMINATION OF A SALE AND SALE PRICE

CHAPTER 16
TAXABLE SALES

CHAPTER 17
EXEMPT SALES

CHAPTER 18
TAXABLE AND EXEMPT SALES DETERMINED BY METHOD OF TRANSACTION OR USAGE

CHAPTER 20
FOODS FOR HUMAN CONSUMPTION, PRESCRIPTION DRUGS, INSULIN, HYPODERMIC SYRINGES, DIABETIC TESTING MATERIALS, PROSTHETIC, ORTHOTIC OR ORTHOPEDIC DEVICES

CHAPTERS 21 to 25
Reserved

TITLE III
SALES TAX ON SERVICES

CHAPTER 26
SALES AND USE TAX ON SERVICES

26.27(422)	Jewelry and watch repair
26.28(422)	Machine operators
26.29(422)	Machine repair of all kinds
26.30(422)	Motor repair
26.31(422)	Motorcycle, scooter and bicycle repair
26.32(422)	Oilers and lubricators
26.33(422)	Office and business machine repair
26.34(422)	Painting, papering and interior decorating
26.35(422)	Parking facilities
26.36(422)	Pipe fitting and plumbing
26.37(422)	Wood preparation
26.38(422)	Private employment agency, executive search agency
26.39(422)	Printing and binding
26.40(422)	Sewing and stitching
26.41(422)	Shoe repair and shoeshine
26.42(422)	Storage warehousing, storage locker, and storage warehousing of raw agricultural products and household goods
26.43(422,423)	Telephone answering service
26.44(422)	Test laboratories
26.45(422)	Termite, bug, roach, and pest eradicators
26.46(422)	Tin and sheet metal repair
26.47(422)	Turkish baths, massage, and reducing salons
26.48(422)	Vulcanizing, recapping or retreading
26.49	Reserved
26.50(422)	Weighing
26.51(422)	Welding
26.52(422)	Well drilling
26.53(422)	Wrapping, packing and packaging of merchandise other than processed meat, fish, fowl and vegetables
26.54(422)	Wrecking service
26.55(422)	Wrecker and towing
26.56(422)	Cable and pay television
26.57(422)	Camera repair
26.58(422)	Campgrounds
26.59(422)	Gun repair
26.60(422)	Janitorial and building maintenance or cleaning
26.61(422)	Lawn care
26.62(422)	Landscaping
26.63(422)	Pet grooming
26.64(422)	Reflexology
26.65(422)	Tanning beds and tanning salons
26.66(422)	Tree trimming and removal
26.67(422)	Water conditioning and softening
26.68(422)	Motor vehicle, recreational vehicle and recreational boat rental
26.69(422)	Security and detective services
26.70	Reserved
26.71(422,423)	Solid waste collection and disposal services
26.72(422,423)	Sewage services
26.73	Reserved
26.74(422,423)	Aircraft rental
26.75(422,423)	Sign construction and installation
26.76(422,423)	Swimming pool cleaning and maintenance

CHAPTER 32
RECEIPTS EXEMPT FROM USE TAX

CHAPTER 33
RECEIPTS SUBJECT TO USE TAX DEPENDING ON METHOD OF TRANSACTION

CHAPTER 34
VEHICLES SUBJECT TO REGISTRATION

CHAPTERS 35 and 36
Reserved

CHAPTER 37
UNDERGROUND STORAGE TANK RULES
INCORPORATED BY REFERENCE

TITLE V
INDIVIDUAL

CHAPTER 38
ADMINISTRATION

CHAPTER 39
FILING RETURN AND PAYMENT OF TAX

CHAPTER 40
DETERMINATION OF NET INCOME

40.36(422)	Exemption of interest earned on bonds issued to finance beginning farmer loan program
40.37(422)	Exemption of interest from bonds issued by the Iowa comprehensive petroleum underground storage tank fund board
40.38(422)	Capital gain deduction or exclusion for certain types of net capital gains
40.39(422)	Exemption of interest from bonds or notes issued to fund the E911 emergency telephone system
40.40(422)	Exemption of active-duty military pay of national guard personnel and armed forces reserve personnel received for services related to operation desert shield
40.41	Reserved
40.42(422)	Depreciation of speculative shell buildings
40.43(422)	Retroactive exemption for payments received for providing unskilled in-home health care services to a relative
40.44(422,541A)	Individual development accounts
40.45(422)	Exemption for distributions from pensions, annuities, individual retirement accounts, or deferred compensation plans received by nonresidents of Iowa
40.46(422)	Taxation of compensation of nonresident members of professional athletic teams
40.47(422)	Partial exclusion of pensions and other retirement benefits for disabled individuals, individuals who are 55 years of age or older, surviving spouses, and survivors
40.48(422)	Health insurance premiums deduction
40.49(422)	Employer social security credit for tips
40.50(422)	Computing state taxable amounts of pension benefits from state pension plans
40.51(422)	Exemption of active-duty military pay of national guard personnel and armed forces military reserve personnel for overseas services pursuant to military orders for peacekeeping in the Bosnia-Herzegovina area
40.52(422)	Mutual funds
40.53(422)	Deduction for contributions by taxpayers to the Iowa educational savings plan trust and addition to income for refunds of contributions previously deducted
40.54(422)	Roth individual retirement accounts
40.55(422)	Exemption of income payments for victims of the Holocaust and heirs of victims
40.56(422)	Taxation of income from the sale of obligations of the state of Iowa and its political subdivisions
40.57(422)	Installment sales by taxpayers using the accrual method of accounting
40.58(422)	Exclusion of distributions from retirement plans by national guard members and members of military reserve forces of the United States
40.59	Reserved
40.60(422)	Additional first-year depreciation allowance
40.61(422)	Exclusion of active duty pay of national guard members and armed forces military reserve members for service under orders for Operation Iraqi Freedom, Operation Noble Eagle, Operation Enduring Freedom or Operation New Dawn
40.62(422)	Deduction for overnight expenses not reimbursed for travel away from home of more than 100 miles for performance of service as a member of the national guard or armed forces military reserve
40.63(422)	Exclusion of income from military student loan repayments
40.64(422)	Exclusion of death gratuity payable to an eligible survivor of a member of the armed forces, including a member of a reserve component of the armed forces who has died while on active duty
40.65(422)	Section 179 expensing
40.66(422)	Deduction for certain unreimbursed expenses relating to a human organ transplant
40.67(422)	Deduction for alternative motor vehicles
40.68(422)	Injured veterans grant program

42.17(15E) Eligible housing business tax credit
42.18(422) Assistive device tax credit
42.19(404A,422) Historic preservation and cultural and entertainment district tax credit for projects with Part 2 applications approved and tax credits reserved prior to July 1, 2014
42.20(422) Ethanol blended gasoline tax credit
42.21(15E) Eligible development business investment tax credit
42.22(15E,422) Venture capital credits
42.23(15) New capital investment program tax credits
42.24(15E,422) Endow Iowa tax credit
42.25(422) Soy-based cutting tool oil tax credit
42.26(15I,422) Wage-benefits tax credit
42.27(422,476B) Wind energy production tax credit
42.28(422,476C) Renewable energy tax credit
42.29(15) High quality job creation program
42.30(15E,422) Economic development region revolving fund tax credit
42.31(422) Early childhood development tax credit
42.32(422) School tuition organization tax credit
42.33(422) E-85 gasoline promotion tax credit
42.34(422) Biodiesel blended fuel tax credit
42.35(422) Soy-based transformer fluid tax credit
42.36(16,422) Agricultural assets transfer tax credit and custom farming contract tax credit
42.37(15,422) Film qualified expenditure tax credit
42.38(15,422) Film investment tax credit
42.39(422) Ethanol promotion tax credit
42.40(422) Charitable conservation contribution tax credit
42.41(15,422) Redevelopment tax credit
42.42(15) High quality jobs program
42.43(16,422) Disaster recovery housing project tax credit
42.44(422) Deduction of credits
42.45(15) Aggregate tax credit limit for certain economic development programs
42.46(422) E-15 plus gasoline promotion tax credit
42.47(422) Geothermal tax credits
42.48(422) Solar energy system tax credit
42.49(422) Volunteer fire fighter, volunteer emergency medical services personnel and reserve peace officer tax credit
42.50(422) Taxpayers trust fund tax credit
42.51(422,85GA,SF452) From farm to food donation tax credit
42.52(422) Adoption tax credit
42.53(15) Workforce housing tax incentives program
42.54(404A,422) Historic preservation and cultural and entertainment district tax credit for projects with Part 2 applications approved on or after July 1, 2014, and agreements entered into on or after July 1, 2014

CHAPTER 43
ASSESSMENTS AND REFUNDS

43.1(422) Notice of discrepancies
43.2(422) Notice of assessment, supplemental assessments and refund adjustments
43.3(422) Overpayments of tax
43.4(68A,422,456A) Optional designations of funds by taxpayer
43.5(422) Abatement of tax

52.19(422) Ethanol blended gasoline tax credit
52.20(15E) Eligible development business investment tax credit
52.21(15E,422) Venture capital credits
52.22(15) New capital investment program tax credits
52.23(15E,422) Endow Iowa tax credit
52.24(422) Soy-based cutting tool oil tax credit
52.25(15I,422) Wage-benefits tax credit
52.26(422,476B) Wind energy production tax credit
52.27(422,476C) Renewable energy tax credit
52.28(15) High quality job creation program
52.29(15E,422) Economic development region revolving fund tax credit
52.30(422) E-85 gasoline promotion tax credit
52.31(422) Biodiesel blended fuel tax credit
52.32(422) Soy-based transformer fluid tax credit
52.33(16,422) Agricultural assets transfer tax credit and custom farming contract tax credit
52.34(15,422) Film qualified expenditure tax credit
52.35(15,422) Film investment tax credit
52.36(422) Ethanol promotion tax credit
52.37(422) Charitable conservation contribution tax credit
52.38(422) School tuition organization tax credit
52.39(15,422) Redevelopment tax credit
52.40(15) High quality jobs program
52.41(15) Aggregate tax credit limit for certain economic development programs
52.42(16,422) Disaster recovery housing project tax credit
52.43(422) E-15 plus gasoline promotion tax credit
52.44(422) Solar energy system tax credit
52.45(422,85GA,SF452) From farm to food donation tax credit
52.46(15) Workforce housing tax incentives program
52.47(404A,422) Historic preservation and cultural and entertainment district tax credit for projects with Part 2 applications approved on or after July 1, 2014, and agreements entered into on or after July 1, 2014

CHAPTER 53
DETERMINATION OF NET INCOME

53.1(422) Computation of net income for corporations
53.2(422) Net operating loss carrybacks and carryovers
53.3(422) Capital loss carryback
53.4(422) Net operating and capital loss carrybacks and carryovers
53.5(422) Interest and dividends from federal securities
53.6(422) Interest and dividends from foreign securities, and securities of state and their political subdivisions
53.7(422) Safe harbor leases
53.8(422) Additions to federal taxable income
53.9(422) Gains and losses on property acquired before January 1, 1934
53.10(422) Work opportunity tax credit and alcohol and cellulosic biofuel fuels credit
53.11(422) Additional deduction for wages paid or accrued for work done in Iowa by certain individuals
53.12(422) Federal income tax deduction
53.13(422) Iowa income taxes and Iowa tax refund
53.14(422) Method of accounting, accounting period
53.15(422) Consolidated returns
53.16(422) Federal rulings and regulations

CHAPTER 58
FILING RETURNS, PAYMENT OF TAX, PENALTY AND INTEREST, AND TAX CREDITS

CHAPTER 59
DETERMINATION OF NET INCOME

CHAPTER 72
EXAMINATION AND CERTIFICATION OF ASSESSORS AND DEPUTY ASSESSORS

CHAPTER 73
PROPERTY TAX CREDIT AND RENT REIMBURSEMENT

CHAPTER 77
DETERMINATION OF VALUE OF UTILITY COMPANIES

CHAPTER 78
REPLACEMENT TAX AND STATEWIDE PROPERTY
TAX ON RATE-REGULATED WATER UTILITIES

REPLACEMENT TAX

STATEWIDE PROPERTY TAX

CHAPTER 79
REAL ESTATE TRANSFER TAX AND DECLARATIONS OF VALUE

CHAPTER 80
PROPERTY TAX CREDITS AND EXEMPTIONS

TITLE X
CIGARETTES AND TOBACCO

CHAPTER 81
ADMINISTRATION

CHAPTER 82
CIGARETTE TAX

CHAPTER 83
TOBACCO TAX

CHAPTER 84
UNFAIR CIGARETTE SALES

CHAPTER 85
TOBACCO MASTER SETTLEMENT AGREEMENT

DIVISION I
TOBACCO MASTER SETTLEMENT AGREEMENT

DIVISION II
TOBACCO PRODUCT MANUFACTURERS' OBLIGATIONS AND PROCEDURES

TITLE XI
INHERITANCE, ESTATE, GENERATION SKIPPING, AND FIDUCIARY INCOME TAX

CHAPTER 86
INHERITANCE TAX

CHAPTER 87
IOWA ESTATE TAX

CHAPTER 88
GENERATION SKIPPING TRANSFER TAX

CHAPTER 89
FIDUCIARY INCOME TAX

CHAPTER 90
Reserved

TITLE XII
MARIJUANA AND CONTROLLED SUBSTANCES STAMP TAX

CHAPTER 91
ADMINISTRATION OF MARIJUANA AND CONTROLLED SUBSTANCES STAMP TAX

CHAPTERS 92 to 96
Reserved

TITLE XIII

CHAPTERS 97 to 101
Reserved

TITLE XIV
HOTEL AND MOTEL TAX

CHAPTER 102
Reserved

CHAPTER 103
STATE-IMPOSED AND LOCALLY IMPOSED HOTEL AND MOTEL TAXES—ADMINISTRATION

CHAPTER 104
HOTEL AND MOTEL—
FILING RETURNS, PAYMENT OF TAX, PENALTY, AND INTEREST

CHAPTER 105
LOCALLY IMPOSED HOTEL AND MOTEL TAX

CHAPTER 106
Reserved

TITLE XV
LOCAL OPTION SALES AND SERVICE TAX

CHAPTER 107
LOCAL OPTION SALES AND SERVICE TAX

CHAPTER 108
LOCAL OPTION SCHOOL INFRASTRUCTURE
SALES AND SERVICE TAX

CHAPTER 109
NEW SCHOOL INFRASTRUCTURE LOCAL OPTION SALES AND SERVICES TAX—
EFFECTIVE ON OR AFTER APRIL 1, 2003, THROUGH FISCAL YEARS
ENDING DECEMBER 31, 2022

CHAPTERS 110 to 119
Reserved

TITLE XVI
REASSESSMENT EXPENSE FUND

CHAPTER 120
REASSESSMENT EXPENSE FUND

CHAPTER 121
Reserved

TITLE XVII
ASSESSOR CONTINUING EDUCATION

CHAPTER 122
ADMINISTRATION

CHAPTER 123
CERTIFICATION

CHAPTER 124
COURSES

CHAPTER 125
REVIEW OF AGENCY ACTION

CHAPTER 126
PROPERTY ASSESSMENT APPEAL BOARD

CHAPTERS 127 to 149
Reserved

TITLE XVIII
DEBT COLLECTION

CHAPTER 150
FEDERAL OFFSET FOR IOWA INCOME TAX OBLIGATIONS

CHAPTER 151
COLLECTION OF DEBTS OWED THE STATE
OF IOWA OR A STATE AGENCY

CHAPTER 152
DEBT COLLECTION AND SELLING OF PROPERTY
TO COLLECT DELINQUENT DEBTS

CHAPTER 153
LICENSE SANCTIONS FOR COLLECTION OF DEBTS OWED THE STATE OF IOWA OR
A STATE AGENCY

CHAPTER 226
AGRICULTURAL RULES

CHAPTERS 227 to 229
Reserved

CHAPTER 230
EXEMPTIONS PRIMARILY BENEFITING MANUFACTURERS AND OTHER PERSONS ENGAGED IN PROCESSING

CHAPTER 42
ADJUSTMENTS TO COMPUTED TAX AND TAX CREDITS
[Prior to 12/17/86, Revenue Department[730]]

701—42.1(257,422) School district surtax. Iowa law provides for the implementation of an income surtax for increasing local school district budgets. The surtax must be approved by the voters of a school district in a special election or by a resolution of the board of directors of a school district. The surtax rate is determined by the department of management on the basis of the revenue to be raised by the surtax for the particular school district with the surtax.

The school district surtax is imposed on the income tax liabilities of all taxpayers residing in the school district on the last day of the taxpayers' tax years. For purposes of the school district surtax, income tax liability is the tax computed under Iowa Code section 422.5, less the nonrefundable credits against computed tax which are authorized in Iowa Code chapter 422, division II.

In a situation where an individual is residing in a school district with a surtax and the individual dies during the tax year, the individual will be considered to be subject to the surtax, since the individual was residing in the school district on the last day of the individual's tax year.

An individual serving in the Armed Forces of the United States who maintains permanent residence in an Iowa school district with a surtax is subject to the surtax regardless of whether the individual is physically residing in the school district on the last day of the tax year.

A person who is present in the school district on the last day of the tax year on a temporary basis due to annual leave or in transit between duty stations is not subject to the surtax.

This rule is intended to implement Iowa Code sections 257.21, 257.29, and 422.15.
[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.2(422D) Emergency medical services income surtax. Effective July 1, 1992, a county board of supervisors may offer for voter approval a local option income surtax, an ad valorem property tax, or a combination of the two taxes to generate revenues for emergency medical services. However, this rule pertains only to the local option income surtax for emergency medical services. If a majority of those voting in the election approve the emergency medical services income surtax, the income surtax will be imposed for tax years beginning on or after January 1 of the fiscal year in which the election is held. Thus, if an election is held in the 2007-2008 fiscal year (July 1, 2007, through June 30, 2008) and the income surtax is approved in the election, the income surtax will be imposed on 2008 returns for individuals filing on a calendar-year basis. In the case of individuals filing on a fiscal-year basis, the income surtax will be imposed on returns for tax years beginning in the 2008 fiscal year. If an emergency medical services income surtax is imposed for a county, it can be imposed only for a maximum period of five years. When the emergency medical income surtax is repealed because the five-year imposition has expired, the income surtax is repealed as of December 31 for tax years beginning on or after that date.

42.2(1) *The rate of the income surtax imposed for emergency medical services.* After the income surtax is approved by an election of county voters, the board of supervisors will set the rate of tax to be imposed, which can be expressed in tenths of 1 percent or hundredths of 1 percent but cannot exceed 1 percent. In addition, because the cumulative total of the percents of income surtax imposed on any taxpayer in the county cannot exceed 20 percent, the rate of an emergency medical services income surtax may be limited, if a school district income surtax has been approved previously by a school district in the county and the surtax rate exceeds 19 percent. Therefore, assuming that a school district in the county had previously approved an income surtax rate of 19.4 percent, the medical emergency income surtax rate would be limited to six-tenths of 1 percent. If a school district income surtax and emergency medical income surtax are approved on or about the same date and the cumulative total of the income surtaxes is greater than 20 percent, the income surtax approved on the earlier of the two dates will be allowed at the rate approved and the second income surtax approved will be limited accordingly so that the cumulative rate will not exceed 20 percent. If a school district income surtax and an emergency medical income surtax are approved on the same date with a proposed cumulative rate that exceeds 20 percent, each of the surtaxes will be reduced equally so that the cumulative surtax rate will not exceed 20 percent. Assuming that a school district in a particular county approves an income surtax of 20 percent

on November 4, 2008, and an emergency medical income surtax of 1 percent is approved on the same date, both surtaxes will be reduced by five-tenths of 1 percent so that the cumulative rate of the two income surtaxes does not exceed 20 percent. The department of management can provide information about any income surtaxes that have been approved for the school districts in the county.

42.2(2) *Imposing the emergency medical income surtax.* The emergency medical income surtax will be imposed on the state income tax liability on each individual residing in the county at the end of the individual's tax year, whether the individual's tax year ends at the end of the calendar year or fiscal year. For purposes of the emergency medical income surtax, an individual's income tax liability is the aggregate of the state income taxes determined in Iowa Code section 422.5 less the nonrefundable credits against computed income tax which are authorized in Iowa Code chapter 422, division II.

42.2(3) *Administering the emergency medical income surtax.* The director of revenue shall administer the emergency medical income surtax in the same way as other state individual tax laws are administered. All powers and requirements related to administering the state income tax law apply to the administration of the emergency medical income surtax including, but not limited to, the provisions of Iowa Code sections 422.4, 422.20 to 422.31, 422.68, 422.70, and 422.72 to 422.75. The county board of supervisors and county officials shall confer with the director for assistance in drafting the ordinance imposing the emergency medical income surtax. Certified copies of the ordinance shall be filed with the department of revenue and the department of management within 30 days after the emergency medical income surtax is approved.

42.2(4) *Accounting for the emergency medical income surtax and paying the surtax.* The department shall account for the emergency medical income surtax and any interest and penalties on the surtax so that there is a separate accounting for each county where the income surtax is imposed. The accounting shall be applicable to those individual income tax returns filed on or before November 1 of the calendar year following the tax year for which the tax is imposed. The emergency medical income surtax and any penalties and interest should be credited to a "local income surtax fund" established in the office of the state treasurer. On or before December 15 of the year after the tax year, the director of revenue shall certify to the state treasurer the income surtax and any interest and penalties collected from returns filed on or before November 1.

This rule is intended to implement Iowa Code chapter 422D.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.3(422) Exemption credits.

42.3(1) A single person shall deduct from the computed tax a personal exemption credit of $40. A single person is defined in 701—subrule 39.4(1).

42.3(2) A married person living with husband or wife at the close of the taxable year, or living with husband or wife at the time of the death of that spouse during the taxable year, shall, if a joint return is filed, deduct from the computed tax a personal exemption of $80. Where such spouse files a separate return, each spouse is entitled to deduct from the computed tax a personal exemption of $40. The personal exemption may not be divided between the spouses in any other proportion.

42.3(3) A taxpayer shall deduct from computed tax an exemption of $40 for each dependent. "Dependent" has the same meaning as provided by the Internal Revenue Code, and the same dependents shall be claimed for Iowa income tax purposes as the taxpayer is entitled to claim for federal income tax purposes. If each spouse furnished 50 percent of the support, the spouses must elect between them which spouse is to be entitled to claim the dependent. The dividing of dependent credits applies only to the number of dependents and not to the credit amount for a particular dependent.

42.3(4) A head of household as defined in 701—subrule 39.4(7) is allowed a personal exemption credit of $80.

42.3(5) A taxpayer who is 65 years of age on or before the first day following the end of the tax year is allowed an additional personal exemption credit of $20 in addition to any other credits allowed by this rule.

42.3(6) A taxpayer who is blind, as defined in Iowa Code section 422.12(1)*"e,"* is allowed a personal exemption credit of $20 in addition to any other credits allowed by this rule.

42.3(7) A nonresident taxpayer or a part-year resident taxpayer will be allowed to deduct personal exemption credits as if the nonresident taxpayer or part-year taxpayer was a resident for the entire year.

This rule is intended to implement Iowa Code section 422.12.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.4(422) Tuition and textbook credit for expenses incurred for dependents attending grades kindergarten through 12 in Iowa. Effective for tax years beginning on or after January 1, 1998, taxpayers who pay tuition and textbook expenses of dependents who attend grades kindergarten through 12 in an Iowa school may receive a tax credit of 25 percent of up to $1,000 of qualifying expenses for each dependent attending an elementary or secondary school located in Iowa. In order for the taxpayer to qualify for the tax credit for tuition and textbooks, the elementary school or secondary school that the dependent is attending must meet the standards for accreditation of public and nonpublic schools in Iowa provided in Iowa Code section 256.11. In addition, the school the dependent is attending must not be operated for profit and must adhere to the provisions of the United States Civil Rights Act of 1964, and the provisions of Iowa Code chapter 216, which is known as the Iowa civil rights Act of 1965. The following definitions and criteria apply to the determination of the tax credit for amounts paid by the taxpayer for tuition and textbooks for a dependent attending an elementary or secondary school in Iowa:

42.4(1) *Tuition.* For purposes of the tuition and textbook tax credit, "tuition" means any charge made by an elementary or secondary school for the expense of personnel, buildings, equipment and materials other than textbooks, and other expenses of elementary or secondary schools which relate to the teaching of only those subjects that are legally and commonly taught in public elementary or secondary schools in Iowa. "Tuition" includes charges by a qualified school for summer school classes or for private instruction of a child who is physically unable to attend classes at the site of the elementary or secondary school.

"Tuition" does not include charges or fees which relate to the teaching of religious tenets, doctrines, or worship in cases where the purpose of the teaching is to inculcate the religious tenets, doctrines, or worship. In addition, "tuition" does not include amounts paid to an individual or other entity for private instruction of a dependent who attends an elementary or secondary school in Iowa. Amounts paid to a school for meals, lodging, or clothing for a dependent do not qualify for the tax credit for tuition.

Amounts paid to an individual or organization for home schooling of a dependent or the teaching of a dependent outside of an elementary or secondary school may not be claimed for purposes of the tuition and textbook tax credit.

42.4(2) *Textbooks.* For purposes of the tuition and textbook tax credit, "textbooks" means books and other instructional materials used in elementary and secondary schools in Iowa to teach only those subjects legally and commonly taught in public elementary and secondary schools in Iowa. "Textbooks" includes fees or charges by the elementary or secondary school for required supplies or materials for classes in art, home economics, shop or similar courses. "Textbooks" also includes books and materials used for extracurricular activities, such as sporting events, musical events, dramatic events, speech activities, driver's education, or programs of a similar nature.

"Textbooks" does not include amounts paid for books or other instructional materials used in the teaching of religious tenets, doctrines, or worship, in cases where the purpose of the teaching is to inculcate the religious tenets, doctrine, or worship. "Textbooks" also does not include amounts paid for books or other instructional materials used in teaching a dependent subjects in the home or outside of an elementary or secondary school.

42.4(3) *Extracurricular activities.* For purposes of the tuition and textbook tax credit, amounts paid for dependents to participate in or to attend extracurricular activities may be claimed as part of the tuition and textbook tax credit. "Extracurricular activities" includes sporting events, musical events, dramatic events, speech activities, driver's education if provided at a school, and programs of a similar nature.

a. The following are specific examples of expenditures related to a dependent's participation in or attendance at extracurricular activities that may qualify for the tuition and textbook tax credit:

(1) Fees for participation in school sports activities.

(2) Fees for field trips.

(3) Rental fees for instruments for school bands or orchestras but not rental fees in rent-to-own contracts.

(4) Driver's education fees, if paid to a school.

(5) Cost of activity tickets or admission tickets to school sporting, music and dramatic events.

(6) Fees for events such as homecoming, winter formal, prom, or similar events.

(7) Rental of costumes for school plays.

(8) Purchase of costumes for school plays if the costumes are not suitable for street wear.

(9) Purchase of track shoes, football shoes, or other athletic shoes with cleats, spikes, or other features that are not suitable for street wear.

(10) Costs of tickets or other admission fees to attend banquets or buffets for school academic or athletic awards.

(11) Trumpet grease, woodwind reeds, guitar picks, violin strings and similar types of items for maintenance of instruments used in school bands or orchestras.

(12) Band booster club or athletic booster club dues, but only if dues are for the dependent attending the school and not the parent or adult.

(13) Rental of formal gown or tuxedo for school dance or other school event.

(14) Dues paid to school clubs or school-sponsored organizations such as chess club, photography club, debate club, or similar organizations.

(15) Amounts paid for music that will be used in school music programs, including vocal music programs.

(16) Fees paid for general materials for shop class, agriculture class, home economics class, or auto repair class and general fees for equivalent classes.

(17) Fees for a dependent's bus trips to attend school if paid to the school.

b. The following are specific examples of expenditures related to a dependent's participation in or attendance at extracurricular activities that will not qualify for the tuition and textbook credit.

(1) Purchase of a musical instrument used in a school band or orchestra.

(2) Purchase of basketball shoes or other athletic shoes that are readily adaptable to street wear.

(3) Amounts paid for special testing such as SAT or PSAT, and for Iowa talent search tests.

(4) Payments for senior trips, band trips, and other overnight school activity trips which involve payment for meals and lodging.

(5) Fees paid to K-12 schools for courses for college credit.

(6) Amounts paid for T-shirts, sweatshirts and similar clothing that is appropriate for street wear.

(7) Amounts paid for special programs at universities and colleges for high school students.

(8) Payment for private instrumental lessons, voice lessons or similar lessons.

(9) Amounts paid for a school yearbook, annual or class ring.

(10) Fees for special materials paid for shop class, agriculture class, auto repair class, home economics class and similar classes. For purposes of this paragraph, "special materials" means materials used for personal projects of the dependents, such as materials to make furniture for personal use, automobile parts for family automobiles and other materials for projects for personal or family benefit.

42.4(4) *Claiming the credit.* The credit can only be claimed by the spouse who claims the dependent credit on the Iowa tax return as described in subrule 42.3(3). For example, for divorced or separated parents, only the spouse who claims the dependent credit on the Iowa return can claim the tuition and textbook credit for tuition and textbook expenses for that dependent.

In cases where married taxpayers file separately on a combined return form, the tuition and textbook credit shall be allocated between the spouses in the ratio in which the dependent credit was claimed between the spouses.

EXAMPLE: A married couple has two dependent children and claimed a tuition and textbook credit of $500 related to both children on their 2011 Iowa return. The taxpayers filed separately on a combined Iowa return form for 2011. One spouse claimed both of the dependent credits on the Iowa return. The $500 tuition and textbook credit will be claimed by the spouse who claimed the dependent credits on the Iowa return.

EXAMPLE: A married couple has three dependent children and claimed a tuition and textbook credit of $600 related to all three children on their 2011 Iowa return. The taxpayers filed separately on a combined Iowa return form for 2011. One spouse claimed one dependent credit, and the other spouse claimed two dependent credits on the Iowa return. The spouse who claimed one dependent credit will claim $200 of the tuition and textbook credit, while the spouse who claimed two dependent credits will claim $400 of the tuition and textbook credit.

This rule is intended to implement Iowa Code section 422.12.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9820B**, IAB 11/2/11, effective 12/7/11]

701—42.5(422) Nonresident and part-year resident credit. For tax years beginning on or after January 1, 1982, an individual who is a nonresident of Iowa for the entire tax year, or an individual who is an Iowa resident for a portion of the tax year, is allowed a credit against the individual's Iowa income tax liability for the Iowa income tax on the portion of the individual's income which was earned outside Iowa while the person was a nonresident of Iowa. This credit is computed on Schedule IA 126, which is included in the Iowa individual income tax booklet. The following subrules clarify how the nonresident and part-year resident credit is computed for nonresidents of Iowa and taxpayers who are part-year residents of Iowa during the tax year.

42.5(1) *Nonresident/part-year resident credit for nonresidents of Iowa.* A nonresident of Iowa shall complete the Iowa individual return in the same way an Iowa resident completes the form by reporting the individual's total net income, including income earned outside Iowa, on the front of the IA 1040 return form. A nonresident individual is allowed the same deduction for federal income tax and the same itemized deductions as an Iowa resident taxpayer with identical deductions for these expenditures. Thus, a nonresident with a taxable income of $40,000 would have the same initial Iowa income tax liability as a resident taxpayer with a taxable income of $40,000 before the nonresident/part-year resident credit is computed.

The nonresident/part-year resident credit is computed on Schedule IA 126. The lines referred to in this subrule are from Schedule IA 126 and Form IA 1040 for the 2008 tax year. Similar lines on the schedule and form may apply for subsequent tax years. The individual's Iowa source net income from lines 1 through 25 of the schedule is totaled on line 26 of the schedule. If the nonresident's Iowa source net income is less than $1,000, the taxpayer is not subject to Iowa income tax and is not required to file an Iowa income tax return for the tax year. However, if the Iowa source net income amount is $1,000 or more, the Iowa source net income is then divided by the person's all source net income on line 27 of Schedule IA 126 to determine the percentage of the Iowa net income to all source net income. This Iowa income percentage, which is rounded to the nearest tenth of a percent, is inserted on line 28 of the schedule, and this percentage is then subtracted from 100 percent to arrive at the nonresident/part-year resident credit percentage or the percentage of the individual's total income which was earned outside Iowa. The nonresident/part-year resident credit percentage is entered on line 29 of Schedule IA 126. The Iowa income tax on total income from line 43 of the IA 1040 is entered on line 30 of Schedule IA 126. The total of nonrefundable credits from line 49 of the IA 1040 is then shown on line 31 of Schedule IA 126. The amount on line 31 is subtracted from the amount on line 30, which results in the Iowa total tax after nonrefundable credits, which is entered on line 32. This Iowa tax-after-credits amount is multiplied by the nonresident/part-year resident credit percentage from line 29 to compute the nonresident/part-year resident credit. The amount of the credit is inserted on line 33 of Schedule IA 126 and on line 51 of the IA 1040.

EXAMPLE A. A single resident of Nebraska had Iowa source net income of $15,000 in 2008 from wages earned from employment in Iowa. The rest of this person's income was attributable to sources outside Iowa. This nonresident of Iowa had an all source net income of $40,000 and a taxable income of $30,000 due to a federal tax deduction of $7,000 and itemized deductions of $3,000. The Iowa income percentage is computed by dividing the Iowa source net income of $15,000 by the taxpayer's all source net income of $40,000, which results in a percentage of 37.5. This percentage is subtracted from 100 percent which leaves a nonresident/part-year resident credit percentage of 62.5.

The Iowa tax from line 43 of the IA 1040 is $1,508. The total nonrefundable credit from line 49 is $40, which leaves a tax amount of $1,468 when the credit is subtracted from $1,508. When $1,468 is multiplied by the nonresident/part-year resident credit percentage of 62.5, a nonresident credit of $918 is computed which is entered on line 33 of Schedule IA 126 as well as on line 51 of the IA 1040 for 2008.

EXAMPLE B. A California resident, who was married, had $20,000 of Iowa source income in 2008 from an Iowa farm. This individual had an additional $80,000 in income that was attributable to sources outside Iowa, but the individual's spouse had no income. The taxpayers had paid $18,000 in federal income tax in 2008 and had itemized deductions of $12,000 in 2008.

The taxpayers' taxable income on their joint Iowa return was $70,000. The taxpayers had an Iowa income tax liability of $4,583 after application of the personal exemption credits of $80. The taxpayers had an Iowa source income of $20,000 and an all source net income of $100,000. Therefore, the Iowa income percentage was 20. Subtracting the Iowa income percentage of 20 percent from 100 percent leaves a nonresident/part-year resident credit percentage of 80.

When the Iowa income tax liability of $4,583 is multiplied by 80 percent, this results in a nonresident/part-year resident credit of $3,666. This credit amount is entered on line 33 of the Schedule IA 126 and on line 51 of Form IA 1040.

42.5(2) *Nonresident/part-year resident credit for part-year residents of Iowa.* An individual who is a resident of Iowa for part of the tax year shall complete the front of the IA 1040 income tax return form as a resident taxpayer by showing the taxpayer's total income, including income earned outside Iowa, on the front of the IA 1040 return form. A part-year resident of Iowa is allowed the same federal tax deduction and itemized deductions as a resident taxpayer who has paid the same amount of federal income tax and has paid for the same deductions that can be claimed on Schedule A in the tax year. Therefore, a part-year resident would have the same initial Iowa income tax liability as an Iowa resident with the same taxable income before computation of the nonresident/part-year resident credit.

The nonresident/part-year resident credit for a part-year resident is computed on Schedule IA 126. The lines referred to in this subrule are from the IA 1040 income tax return form and the Schedule IA 126 for 2008. Similar lines may apply for tax years after 2008. The individual's Iowa source income is totaled on line 26 of Schedule IA 126 and includes all the individual's income received while the taxpayer was a resident of Iowa and all the Iowa source income received during the period of the tax year when the individual was a resident of a state other than Iowa. Iowa source income includes, but is not limited to, wages earned in Iowa while a resident of another state as well as income from Iowa farms and other Iowa businesses that was earned during the portion of the year that the taxpayer was a nonresident of Iowa. In the case of interest from a part-year resident's account at an Iowa financial institution, only interest earned during the period of the individual's Iowa residence is Iowa source income unless the account is for an Iowa business. If the part-year resident's account at a financial institution is for an Iowa business, all interest earned in the year by the part-year resident from the account is taxable to Iowa.

Income earned outside Iowa by the part-year resident during the portion of the year the individual was an Iowa resident is taxable to Iowa and is part of the individual's Iowa source income. To compute the nonresident/part-year resident credit for a part-year resident, the taxpayer's Iowa source income on Schedule IA 126 is totaled. If the Iowa source income is less than $1,000, the taxpayer is not subject to Iowa income tax and is not required to file an Iowa return. If the Iowa source income is $1,000 or more, it is divided by the taxpayer's all source net income on line 27 of Schedule IA 126. The percentage computed by this procedure is the Iowa income percentage and is entered on line 28 of the Schedule IA 126. The Iowa income percentage, which is rounded to the nearest tenth of a percent, is then subtracted from 100 percent to arrive at the nonresident/part-year resident credit percentage, which is entered on line 29 of Schedule IA 126. The Iowa tax from line 43 of the IA 1040 is then shown on line 30 of Schedule IA 126. The total of the Iowa nonrefundable credits from line 49 of the IA 1040 is entered on line 31 of Schedule IA 126 and is subtracted from the Iowa tax amount on line 30. The tax-after-credits amount on line 32 is next multiplied by the nonresident/part-year resident credit percentage from line 28. The amount calculated from this procedure is the nonresident/part-year resident credit, which is shown on line 33 of Schedule IA 126 and on line 51 of Form IA 1040.

EXAMPLE A. A single individual was a resident of Nebraska for the first half of 2008 and moved to Iowa on July 1, 2008, to accept a job in Des Moines. This individual earned $20,000 from wages, $200 from interest, and $4,000 from a ranch in Nebraska from January 1, 2008, through June 30, 2008. In the last half of 2008, this person had wages of $30,000, interest income of $300, and $4,000 from the Nebraska ranch. This part-year resident had federal income tax paid in 2008 of $11,000 and had itemized deductions of $3,000.

The part-year resident's all source net income was $58,500 and the Iowa source net income was $34,300, which includes the Iowa wages, the Nebraska ranch income of $4,000 earned during the individual's period of Iowa residence, as well as the interest income of $300 earned during that time of the tax year. The Iowa taxable income for the part-year resident for 2008 was $44,500, which included the federal income tax deduction of $11,000 and itemized deductions of $3,000. The individual's Iowa income percentage was 58.6 which was determined by dividing the Iowa source income of $34,300 by the all source income of $58,500. Subtracting the Iowa income percentage of 58.6 from 100 percent results in a nonresident/part-year resident credit percentage of 41.4. The Iowa tax on total income was $2,529 which was reduced to $2,489 after subtraction of the personal exemption credit of $40.

When $2,489 is multiplied by the nonresident/part-year resident percentage of 41.4, a nonresident/part-year resident credit of $1,030 is computed for this part-year resident.

EXAMPLE B. A single individual moved from Minnesota to Iowa on July 1, 2008. This person had received $5,000 in income from an Iowa farm in March of the tax year and another $10,000 from this farm in September of 2008. This person had $10,000 in wages from employment in Minnesota in the first half of the year and another $15,000 in wages from employment in Iowa in the last half of 2008. This person had $2,000 in interest from a Minnesota bank in the first half of the year and $2,000 in interest from an Iowa bank in the last six months of 2008. This taxpayer had $8,000 in federal income tax withheld from wages in 2008 and claimed the standard deduction on both the Iowa and federal income tax returns.

The part-year resident's all source income was $44,000 and the Iowa source income was $32,000 which consisted of $15,000 in wages, $2,000 in interest income, and $15,000 in income from the Iowa farm. Since the farm was in Iowa, the farm income received in the first half of 2008 was taxable to Iowa as well as the farm income received while the individual was an Iowa resident. The individual's Iowa taxable income was $34,250 which was computed after subtracting the federal income tax deduction of $8,000 and a standard deduction of $1,750. The taxpayer's Iowa income tax liability was $1,757 after subtraction of a personal exemption credit of $40.

The taxpayer's Iowa income percentage was 72.7 which was computed by dividing the Iowa source income of $32,000 by the all source income of $44,000. The nonresident/part-year resident credit percentage was 27.3 which was arrived at by subtracting the Iowa income percentage of 72.7 from 100 percent. The taxpayer's nonresident/part-year resident credit is $480. This was determined by multiplying the Iowa income tax liability after personal exemption credit amount of $1,757 by the nonresident/part-year resident percentage of 27.3.

This rule is intended to implement Iowa Code section 422.5.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 1665C**, IAB 10/15/14, effective 11/19/14]

701—42.6(422) Out-of-state tax credits.

42.6(1) *General rule.* Iowa residents are allowed an out-of-state tax credit for taxes paid to another state or foreign country on income which is also reported on the taxpayer's Iowa return. The out-of-state tax credit is allowable only if the taxpayer files an Iowa resident income tax return.

If the Iowa resident is a partner, shareholder, member, or beneficiary of a partnership, S corporation, limited liability company, or trust which files a composite income tax return in another state on behalf of the partners, shareholders, members or beneficiaries, the out-of-state tax credit will be allowed for the Iowa resident. The Iowa resident must provide a schedule of the resident's share of the income tax paid to another state on a composite basis, and the out-of-state tax credit is limited based upon the calculation set forth in subrule 42.6(2).

However, if the partnership, S corporation, limited liability company or trust is directly subject to tax in another state and the tax is not directly imposed on the resident taxpayer, then the out-of-state tax credit is not allowed for the Iowa resident on the tax directly imposed on the partnership, S corporation, limited liability company, or trust. For example, if another state does not recognize the S corporation election for state purposes and a corporation income tax is imposed directly on the S corporation, then the out-of-state tax credit is not allowed for the Iowa resident shareholder on the corporation income tax paid to the other state.

42.6(2) *Limitation of out-of-state tax credit.* If an Iowa resident taxpayer pays income tax to another state or foreign country on any of the taxpayer's income, the taxpayer is entitled to a net tax credit; that is, the taxpayer may deduct from the taxpayer's Iowa net tax (not from gross income) the amount of income tax actually paid to the other state or country, provided the amount deducted as a credit does not exceed the amount of Iowa net income tax on the same income which was taxed by the other state or foreign country.

42.6(3) *Computation of tax credit.*

a. The limitation on the tax credit must be computed according to the following formula: Gross income taxed by another state or foreign country that is also taxed by Iowa shall be divided by the total gross income of the Iowa resident taxpayer. This quotient, multiplied by the net Iowa tax as determined on the total gross income of the taxpayer as if entirely earned in Iowa, shall be the maximum tax credit against the Iowa net tax. This quotient shall be computed as a percentage rounded to the nearest tenth of a percent. However, if the income tax paid to the other state or foreign country on the gross income taxed by the other state or foreign country is less than the maximum tax credit against the Iowa tax, the out-of-state credit allowed against the Iowa tax may not exceed the income tax paid to the other state or foreign country. The income tax paid to the other state or foreign country is the net state or foreign income tax actually paid for the tax year on the income taxed by the other state or foreign country and not the state or foreign income tax paid during the tax year, such as state income tax or foreign income tax withheld from the income taxed by the other state or foreign country.

b. Out-of-state tax credit examples. An individual who is an Iowa resident for the entire tax year can claim an out-of-state tax credit against the person's Iowa income tax liability for any income tax paid to another state or foreign country for the tax year on any gross income received by the individual for the year which was derived from sources outside of Iowa to the extent this gross income is also subject to Iowa income tax.

However, in the case of an individual who is a part-year resident of Iowa for the tax year, that individual can only claim an out-of-state tax credit against the person's Iowa income tax liability for income tax paid to another state or foreign country on gross income derived from sources outside of Iowa during the period of the tax year that the individual was an Iowa resident and only to the extent this gross income derived from sources outside of Iowa was also subject to Iowa income tax.

The taxpayer's out-of-state credit is computed on Schedule IA 130 which is to be filed with the taxpayer's Iowa individual income tax return. The taxpayer's income tax return or other document of the other state or foreign country supporting the income tax paid to the other state or foreign country shall be filed with the individual's Iowa income tax return to support the out-of-state tax credit claimed.

EXAMPLE 1. Gene Miller was an Iowa resident for the entire year 2008. Mr. Miller lived in Council Bluffs and worked the entire year for a company in Omaha, Nebraska. Mr. Miller had wages of $30,000 and Nebraska income tax withheld of $1,000. He also had income of $10,000 from rental of an Iowa farm and another $10,000 in interest income from a personal savings account in an Iowa bank. The amount of Mr. Miller's gross income that was taxed by Nebraska (the other state or foreign country) was $30,000. His total gross income in 2008 was $50,000. Thus, 60 percent of his income was earned in Nebraska. Mr. Miller's Iowa tax on line 54 of Form IA 1040 was $917, which resulted in a potential out-of-state credit of 60 percent of the Iowa tax or $550 because 60 percent of Mr. Miller's income was earned outside Iowa and was taxed by Nebraska. However, Mr. Miller's income tax liability on the Nebraska income tax return was only $500. Thus, the out-of-state tax credit allowed was $500, because that was less than the potential out-of-state tax credit of $550.

EXAMPLE 2. Ben Smith was a part-year Iowa resident in 2008. He resided in Missouri for the first six months of the year until he moved to Keokuk, Iowa, on July 1. Mr. Smith was employed in Missouri for the entire year and had wages of $30,000 and had Missouri income tax liability of $1,000. Half of Mr. Smith's wages or $15,000 of the wages was earned during the time Mr. Smith was an Iowa resident. Mr. Smith also had $10,000 in farm rental income from farmland located in Iowa. The amount of gross income taxed by Missouri while Mr. Smith was an Iowa resident was $15,000. Mr. Smith's gross income earned while an Iowa resident for the year was $25,000. Thus, 60 percent of the gross income was earned in the other state while Mr. Smith was an Iowa resident. Mr. Smith's Iowa income tax on line 54 of the IA 1040 was $1,292. This resulted in a potential out-of-state credit of $775 because 60 percent of the gross income was earned in Missouri during the period Mr. Smith was an Iowa resident. However, since 50 percent of the income earned in Missouri was earned while Mr. Smith was a resident of Iowa and the Missouri income tax liability for the year was $1,000, the out-of-state credit was $500 or 50 percent of the Missouri income tax liability. The out-of-state credit allowed was $500, because this was less than the Iowa income tax of $775 that was applicable to the gross income earned in Missouri during the period Mr. Smith was an Iowa resident.

42.6(4) *Proof of claim for tax credit.* The credit may be deducted from Iowa net income tax if written proof of such payment to another state or foreign country is furnished to the department. The department will accept any one of the following as proof of such payment:

a. A photocopy, or other similar reproduction, of either:

(1) The receipt issued by the other state or foreign country for payment of the tax, or

(2) The canceled check (both sides) with which the tax was paid to the other state or foreign country together with a statement of the amount and kind (whether wages, salaries, property or business) of total income on which such tax was paid.

b. A copy of the income tax return filed with the other state or foreign country which has been certified by the tax authority of that state or foreign country and showing thereon that the income tax assessed has been paid to them.

This rule is intended to implement Iowa Code section 422.8.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 1665C**, IAB 10/15/14, effective 11/19/14]

701—42.7(422) Out-of-state tax credit for minimum tax.

42.7(1) *General rule.* Iowa residents are allowed an out-of-state tax credit for minimum taxes or income taxes paid to another state or foreign country on preference items derived from sources outside of Iowa. Part-year residents who pay minimum tax to another state or foreign country on preference items derived from sources outside Iowa will be allowed an out-of-state tax credit only to the extent that the minimum tax paid to the other state or foreign country relates to preference items that occurred during the period the taxpayer was an Iowa resident. Taxpayers who were nonresidents of Iowa for the entire tax year are not eligible for an out-of-state tax credit on their Iowa returns for minimum taxes paid to another state or foreign country on preference items.

If the Iowa resident is a partner, shareholder, member, or beneficiary of a partnership, S corporation, limited liability company, or trust which files a composite income tax return and pays minimum tax in another state on behalf of the partners, shareholders, members or beneficiaries, the out-of-state tax credit will be allowed for the Iowa resident. The Iowa resident must provide a schedule of the resident's share of the minimum tax paid to another state on a composite basis, and the out-of-state tax credit is limited based upon the calculation set forth in subrule 42.7(2).

However, if the partnership, S corporation, limited liability company, or trust is directly subject to minimum tax in another state and the minimum tax is not directly imposed on the resident taxpayer, then the out-of-state tax credit is not allowed for the Iowa resident on the minimum tax directly imposed on the partnership, S corporation, limited liability company, or trust. For example, if another state does not recognize the S corporation election for state tax purposes and a corporation income tax is imposed directly on the S corporation which includes minimum tax, then the out-of-state tax credit is not allowed for the Iowa resident shareholder on the corporation income tax, including minimum tax, paid to the other state.

42.7(2) *Limitation of out-of-state tax credit for minimum tax.* The limitation on the out-of-state tax credit for minimum tax is that the credit shall not exceed the Iowa minimum tax that would have been computed on the same preference items which were taxed by the other state or foreign country. The limitation may be determined according to the following formula: The total of preference items earned outside of Iowa and taxed by another state or foreign country shall be divided by the total of preference items of the resident taxpayer. This quotient, multiplied by the state minimum tax on the total of preference items as if entirely earned in Iowa, shall be the maximum credit against the Iowa minimum tax. However, if the minimum tax imposed by the other state or foreign country is less than the minimum tax computed under the limitation formula, the out-of-state credit for minimum tax will not exceed the minimum tax imposed by the other state or foreign country.

No out-of-state credit will be allowed on the Iowa return for minimum tax paid to another state or foreign country to the extent that the minimum tax of the other state or foreign country is imposed on items of tax preference not subject to the Iowa minimum tax. In addition, no out-of-state credit will be allowed for minimum tax paid to another state or foreign country of capital gains or losses from distressed sales which are excluded from the Iowa minimum tax. Capital gains or losses from distressed sales are described in rule 701—40.27(422).

42.7(3) *Proof of claim for out-of-state tax credit for minimum tax.* The out-of-state credit for minimum tax may be claimed on the return of a taxpayer if proof of payment of minimum tax to the state or foreign country is included with the return. Documents needed for proof of payment are a photocopy of the minimum tax form of the state or country to which minimum tax was paid as well as instructions from the minimum tax form or other information which specifies how the minimum tax is imposed and what preference items are subject to the minimum tax of that state or foreign country.

In the case of audit by the department of a taxpayer claiming an out-of-state tax credit for minimum tax paid, the department may require additional proof of payment of the out-of-state tax credit. The department will accept any of the following documents as verification of payment of the minimum tax:

a. A photocopy, or other similar reproduction, of either:

(1) The receipt issued by the other state or foreign country for payment of the tax, including the minimum tax, or

(2) The canceled check (both sides) which was used for payment of the minimum tax to the other state or foreign country.

b. A copy of the return filed with the other state or foreign country which has been certified by the tax authority of that state or foreign country and which shows that the income tax, including the minimum tax, has been paid.

This rule is intended to implement Iowa Code section 422.8.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.8(422) Withholding and estimated tax credits. An employee from whose wages tax is withheld shall claim credit for the tax withheld on the employee's income tax return for the year during which the tax was withheld. Credit will be allowed only if a copy of the withholding statement is attached to the return. Taxpayers who have made estimated income tax payments shall claim credit for the estimated tax paid for the taxable year.

This rule is intended to implement Iowa Code section 422.16.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.9(422) Motor fuel credit. An individual, partnership, limited liability company, or S corporation may elect to receive an income tax credit in lieu of the motor fuel tax refund provided by Iowa Code chapter 452A. An individual, partnership, limited liability company, or S corporation which holds a motor fuel tax refund permit under Iowa Code section 452A.18 when it makes this election must cancel the permit within 30 days after the first day of the tax year. However, if the refund permit is not canceled within this period, the permit becomes invalid at the time the election to receive an income tax credit is made. The election will continue for subsequent tax years unless a new motor fuel tax refund permit is obtained.

The motor fuel income tax credit must be the amount of Iowa motor fuel tax paid on qualifying fuel purchases as determined by Iowa Code chapter 452A and Iowa Code section 422.110 less any state sales tax as determined by 701—subrule 231.2(2). The credit must be claimed on the tax return covering the tax year in which the motor fuel tax was paid. If the motor fuel credit results in an overpayment of income tax, the overpayment may be refunded or may be credited to income tax due in the subsequent tax year.

The motor fuel tax credits for fuel taxes paid by partnerships, limited liability companies, and S corporations are not claimed on returns filed for the partnerships, limited liability companies, and S corporations. Instead, the pro rata shares of the motor fuel tax credits are allocated to the partners, members, and shareholders in the same ratio as incomes are allocated to the partners, members, and shareholders. A schedule must be attached to the individual's returns showing the distribution of gallons and the amount of credit claimed by each partner, member, or shareholder.

The partnership, limited liability company, or S corporation must attach to its return a schedule showing the allocation to each partner, member, or shareholder of the motor fuel purchased by the partnership, limited liability company, or S corporation which qualifies for the credit.

This rule is intended to implement Iowa Code sections 422.110 and 422.111.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.10(422) Alternative minimum tax credit for minimum tax paid in a prior tax year. Minimum tax paid in prior tax years commencing with tax years beginning on or after January 1, 1987, by a taxpayer can be claimed as a tax credit against the taxpayer's regular income tax liability in a subsequent tax year. Therefore, 1988 is the first tax year that the minimum tax credit is available, and the credit is based on the minimum tax paid by the taxpayer for 1987. The minimum tax credit may only be used against regular income tax for a tax year to the extent that the regular tax is greater than the minimum tax for the tax year. If the minimum tax credit is not used against the regular tax for a tax year, the remaining credit is carried over to the following tax year to be applied against the regular income tax liability for that period. The minimum tax credit is computed on Form IA 8801.

42.10(1) *Examples of computation of the minimum tax credit and carryover of the credit.*

EXAMPLE 1. The taxpayers reported $5,000 of minimum tax for 2007. For 2008, the taxpayers reported regular tax of $8,000, and the minimum tax liability is $6,000. The minimum tax credit is $2,000 for 2008 because, although the taxpayers had an $8,000 regular tax liability, the credit is allowed only to the extent that the regular tax exceeds the minimum tax. Since only $2,000 of the carryover credit from 2007 was used, there is a $3,000 minimum tax carryover credit to 2009.

EXAMPLE 2. The taxpayers reported $2,500 of minimum tax for 2007. For 2008, the taxpayers reported regular tax of $8,000, and the minimum tax liability is $5,000. The minimum tax credit is $2,500 for 2008 because, although the regular tax exceeded the minimum tax by $3,000, the credit is allowed only to the extent of minimum tax paid for prior tax years. There is no minimum tax carryover credit to 2009.

42.10(2) *Minimum tax credit for nonresidents and part-year residents.* Nonresident and part-year resident taxpayers who paid Iowa minimum tax in tax years beginning on or after January 1, 1987, are eligible for the minimum tax credit to the extent that the minimum tax they paid was attributable to tax preferences and adjustments. Therefore, if a nonresident or part-year resident taxpayer had Iowa source tax preferences or adjustments, then all the minimum tax that was paid would qualify for the minimum tax credit.

The minimum tax credit for a tax year as computed above applies to the regular income tax liability less the nonresident part-year credit to the extent this regular tax amount exceeds the minimum tax for the tax year. To the extent the credit is not used, the credit can be carried over to the next tax year.

This rule is intended to implement Iowa Code section 422.11B.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 2829C**, IAB 11/23/16, effective 1/1/17]

701—42.11(15,422) Research activities credit. Effective for tax years beginning on or after January 1, 1985, taxpayers are allowed a credit equal to 6½ percent of the state's apportioned share of qualified expenditures for increasing research activities. Effective for tax years beginning on or after January 1,

1991, the Iowa research activities credit will be computed on the basis of the qualifying expenditures for increasing research activities as allowable under Section 41 of the Internal Revenue Code in effect on January 1, 1999. The state's apportioned share of the qualifying expenditures for increasing research activities is a percent equal to the ratio of qualified research expenditures in Iowa to the total qualified research expenditures. The Iowa research activities credit is made permanent for tax years beginning on or after January 1, 1991, even though there may no longer be a research activities credit for federal income tax purposes.

42.11(1) Qualified expenditures in Iowa are:

a. Wages for qualified research services performed in Iowa.

b. Cost of supplies used in conducting qualified research in Iowa.

c. Rental or lease cost of personal property used in Iowa in conducting qualified research. Where personal property is used both within and without Iowa in conducting qualified research, the rental or lease cost must be prorated between Iowa and non-Iowa use by the ratio of days used in Iowa to total days used both within and without Iowa.

d. Sixty-five percent of contract expenses paid by a corporation to a qualified organization for basic research performed in Iowa.

42.11(2) Total qualified expenditures are:

a. Wages paid for qualified research services performed everywhere.

b. Cost of supplies used in conducting qualified research everywhere.

c. Rental or lease cost of personal property used in conducting qualified research everywhere.

d. Sixty-five percent of contract expenses paid by a corporation to a qualified organization for basic research performed everywhere.

"Qualifying expenditures for increasing research activities" is the smallest of the amount by which the qualified research expenses for the taxable year exceed the base period research expenses or 50 percent of the qualified research expenses for the taxable year.

A taxpayer may claim on the taxpayer's individual income tax return the pro rata share of the credit for qualifying research expenditures incurred in Iowa by a partnership, subchapter S corporation, or estate or trust. The portion of the credit claimed by the individual must be in the same ratio as the individual's pro rata share of the earnings of the partnership, subchapter S corporation, or estate or trust.

Any research credit in excess of the individual's tax liability, less the nonrefundable credits authorized in Iowa Code chapter 422, division II, may be refunded to the taxpayer or may be credited to the estimated tax of the taxpayer for the following year.

42.11(3) Research activities credit for tax years beginning in 2000. Effective for tax years beginning on or after January 1, 2000, the taxes imposed for individual income tax purposes will be reduced by a tax credit for increasing research activities in this state.

a. The credit equals the sum of the following:

(1) Six and one-half percent of the excess of qualified research expenses during the tax year over the base amount for the tax year based upon the state's apportioned share of the qualifying expenditures for increasing research activities.

(2) Six and one-half percent of the basic research payments determined under Section 41(e)(1)(A) of the Internal Revenue Code during the tax year based upon the state's apportioned share of the qualifying expenditures for increasing research activities. The state's apportioned share of the qualifying expenditures for increasing research activities is a percent equal to the ratio of qualified research expenditures in this state to total qualified research activities.

b. In lieu of the credit computed under paragraph 42.11(3)*"a,"* a taxpayer may elect to compute the credit amount for qualified research expenses incurred in this state in a manner consistent with the alternative incremental credit described in Section 41(c)(4) of the Internal Revenue Code for tax years beginning on or after January 1, 2000, but beginning before January 1, 2010. The taxpayer may make this election regardless of the method used by the taxpayer on the taxpayer's federal income tax return. The election made under this paragraph is for the tax year, and the taxpayer may use another method or this same method for any subsequent tax year. For purposes of this alternative incremental research credit computation, the credit percentages applicable to qualified research expenses described in clauses

(i), (ii), and (iii) of Section 41(c)(4)(A) of the Internal Revenue Code are 1.65 percent, 2.20 percent, and 2.75 percent, respectively.

c. In lieu of the credit computed under paragraph 42.11(3)*"a,"* a taxpayer may elect to compute the credit amount for qualified research expenses incurred in this state in a manner consistent with the alternative simplified credit described in Section 41(c)(5) of the Internal Revenue Code for tax years beginning on or after January 1, 2010. The taxpayer may make this election regardless of the method used by the taxpayer on the taxpayer's federal income tax return. The election made under this paragraph is for the tax year, and the taxpayer may use another method or this same method for any subsequent tax year.

For purposes of this alternative simplified research credit computation, the credit percentages applicable to qualified research expenses described in Section 41(c)(5)(A) and clause (ii) of Section 41(c)(5)(B) of the Internal Revenue Code are 4.55 percent and 1.95 percent, respectively.

d. For purposes of this subrule, the terms "base amount," "basic research payment," and "qualified research expense" mean the same as defined for the federal credit for increasing research activities under Section 41 of the Internal Revenue Code, except that, for purposes of the alternative incremental credit described in paragraph 42.11(3)*"b"* and the alternative simplified credit described in paragraph 42.11(3)*"c,"* such amounts are limited to research activities conducted within this state. For purposes of this subrule, "Internal Revenue Code" means the Internal Revenue Code in effect on January 1, 2014.

e. An individual may claim a research activities credit incurred by a partnership, S corporation, limited liability company, estate, or trust electing to have the income of the business entity taxed to the individual. The amount claimed by an individual from the business entity shall be based upon the pro rata share of the individual's earnings from a partnership, S corporation, estate or trust. Any research credit in excess of the individual's tax liability, less the nonrefundable credits authorized in Iowa Code chapter 422, division II, may be refunded to the individual or may be credited to the individual's tax liability for the following tax year.

f. An eligible business approved under the new jobs and income program prior to July 1, 2005, is eligible for an additional research activities credit as described in 701—subrule 52.7(4). An eligible business approved under the enterprise zone program is eligible for an additional research activities credit as described in 701—subrules 52.7(5) and 52.7(6).

g. Tax years ending on or after July 1, 2005, but before July 1, 2009. For eligible businesses approved under the enterprise zone program and the high quality job creation program, research activities allowable for the Iowa research activities credit include expenses related to the development and deployment of innovative renewable energy generation components manufactured or assembled in Iowa. These expenses are not eligible for the federal credit for increasing research activities. These innovative renewable energy generation components do not include components with more than 200 megawatts in installed effective nameplate capacity. The research activities credit related to renewable energy generation components under the enterprise zone program and the high quality job creation program shall not exceed $1 million in the aggregate.

These expenses are available only for the additional research activities credit set forth in subrule 42.11(3), paragraph *"f,"* for businesses in enterprise zones and the additional research activities credit set forth in subrule 42.29(1) for businesses approved under the high quality job creation program. These expenses are not available for the research activities credit set forth in subrule 42.11(3), paragraphs *"a," "b"* and *"c."*

h. Tax years ending on or after July 1, 2009. For eligible businesses approved under the enterprise zone program prior to July 1, 2014, research activities allowable for the Iowa research activities credit include expenses related to the development and deployment of innovative renewable energy generation components manufactured or assembled in Iowa; such expenses related to the development and deployment of innovative renewable energy generation components are not eligible for the federal credit for increasing research activities. The enterprise zone program was repealed on July 1, 2014. However, any research activities credit earned by businesses approved under the enterprise zone program prior to July 1, 2014, remains valid and can be claimed on tax returns filed after July 1, 2014.

(1) For purposes of this paragraph, innovative renewable energy generation components do not include components with more than 200 megawatts in installed effective nameplate capacity.

(2) The research activities credit related to renewable energy generation components under the enterprise zone program and the high quality jobs program described in subrule 42.42(1) shall not exceed $2 million for the fiscal year ending June 30, 2010, and $1 million for the fiscal year ending June 30, 2011.

(3) These expenses related to the development and deployment of innovative renewable energy generation components are applicable only to the additional research activities credit set forth in subrule 42.11(3), paragraph *"f,"* for businesses in enterprise zones and the additional research activities credit set forth in subrule 42.42(1) for businesses approved under the high quality jobs program, and are not applicable to the research activities credit set forth in subrule 42.11(3), paragraphs *"a," "b"* and *"c."*

42.11(4) Reporting of research activities credit claims. Beginning with research activities credit claims filed on or after July 1, 2009, the department shall issue an annual report to the general assembly of all research activities credit claims in excess of $500,000. The report, which is due by February 15 of each year, will contain the name of each claimant and the amount of the research activities credit for all claims filed during the previous calendar year in excess of $500,000.

This rule is intended to implement Iowa Code sections 15.335 and 422.10 as amended by 2014 Iowa Acts, House File 2435.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10; **ARC 9820B**, IAB 11/2/11, effective 12/7/11; **ARC 0337C**, IAB 9/19/12, effective 10/24/12; **ARC 1101C**, IAB 10/16/13, effective 11/20/13; **ARC 1545C**, IAB 7/23/14, effective 8/27/14; **ARC 1744C**, IAB 11/26/14, effective 12/31/14]

701—42.12(422) New jobs credit. A tax credit is available to an individual who has entered into an agreement under Iowa Code chapter 260E and has increased employment by at least 10 percent.

42.12(1) *Definitions.*

a. The term "new jobs" means those jobs directly resulting from a project covered by an agreement authorized by Iowa Code chapter 260E (Iowa industrial new jobs training Act) but does not include jobs of recalled workers or replacement jobs or other jobs that formerly existed in the industry in this state.

b. The term "jobs directly related to new jobs" means those jobs which directly support the new jobs but do not include in-state employees transferred to a position which would be considered to be a job directly related to new jobs unless the transferred employee's vacant position is filled by a new employee. The burden of proof that a job is directly related to new jobs is on the taxpayer.

EXAMPLE A. A taxpayer who has entered into a chapter 260E agreement to train new employees for a new product line, transfers an in-state employee to be foreman of the new product line but does not fill the transferred employee's position. The new foreman's position would not be considered a job directly related to new jobs even though it directly supports the new jobs because the transferred employee's old position was not refilled.

EXAMPLE B. A taxpayer who has entered into a chapter 260E agreement to train new employees for a new product line transfers an in-state employee to be foreman of the new product line and fills the transferred employee's position with a new employee. The new foreman's position would be considered a job directly related to new jobs because it directly supports the new jobs and the transferred employee's old position was filled by a new employee.

c. The term "taxable wages" means those wages upon which an employer is required to contribute to the state unemployment fund as defined in Iowa Code subsection 96.19(37) for the year in which the taxpayer elects to take the new jobs tax credit. For fiscal year taxpayers, "taxable wages" shall not be greater than the maximum wage upon which an employer is required to contribute to the state unemployment fund for the calendar year in which the taxpayer's fiscal year begins.

d. The term "agreement" means an agreement entered into under Iowa Code chapter 260E after July 1, 1985, an amendment to that agreement, or an amendment to an agreement entered into before July 1, 1985, if the amendment sets forth the base employment level as of the date of the amendment. The term "agreement" also includes a preliminary agreement entered into under Iowa Code chapter 260E provided the preliminary agreement contains all the elements of a contract and includes the necessary elements and commitments relating to training programs and new jobs.

e. The term "base employment level" means the number of full-time jobs an industry employs at a plant site which is covered by an agreement under Iowa Code chapter 260E on the date of the agreement.

f. The term "project" means a training arrangement which is the subject of an agreement entered into under Iowa Code chapter 260E.

g. The term "industry" means a business engaged in interstate or intrastate commerce for the purpose of manufacturing, processing, or assembling products, conducting research and development, or providing services in interstate commerce, but excludes retail, health, and professional services. "Industry" does not include a business which closes or substantially reduces its operations in one area of the state and relocates substantially the same operation in another area of the state. "Industry" is a business engaged in the above-listed activities rather than the generic definition encompassing all businesses in the state engaged in the same activities. For example, in the meat-packing business, an industry is considered to be a single corporate entity or operating division, rather than the entire meat-packing business in the state.

h. The term "new employees" means the same as new jobs or jobs directly related to new jobs.

i. The term "full-time job" means any of the following:

(1) An employment position requiring an average work week of 35 or more hours;

(2) An employment position for which compensation is paid on a salaried full-time basis without regard to hours worked; or

(3) An aggregation of any number of part-time or job-sharing employment positions which equal one full-time employment position. For purposes of this subrule, each part-time or job-sharing employment position shall be categorized with regard to the average number of hours worked each week as one-quarter, half, three-quarters, or full-time position, as set forth in the following table:

Average Number of Weekly Hours	**Category**
More than 0 but less than 15	¼
15 or more but less than 25	½
25 or more but less than 35	¾
35 or more	1 (full-time)

42.12(2) *How to compute the credit.* The credit is 6 percent of the taxable wages paid to employees in new jobs or jobs directly related to new jobs for the taxable year in which the taxpayer elects to take the credit.

EXAMPLE 1. A taxpayer enters into an agreement to increase employment by 20 new employees which is greater than 10 percent of the taxpayer's base employment level of 100 employees. In year one of the agreement, the taxpayer hires 20 new employees but elects not to take the credit in that year. In year two of the agreement, only 18 of the new employees hired in year one are still employed and the taxpayer elects to take the credit. The credit would be 6 percent of the taxable wages of the 18 remaining new employees. In year three of the agreement, the taxpayer hires two additional new employees under the agreement to replace the two employees that left in year two and elects to take the credit. The credit would be 6 percent of the taxable wages paid to the two replacement employees. In year four of the agreement, three of the employees for which a credit had been taken left employment and three additional employees were hired. No credit is available for these employees. A credit can only be taken one time for each new job or job directly related to a new job.

EXAMPLE 2. A taxpayer operating two plants in Iowa enters into a chapter 260E agreement to train new employees for a new product line at one of the taxpayer's plants. The base employment level on the date of the agreement at plant A is 300 and at plant B is 100. Under the agreement, 20 new employees will be trained for plant B which is greater than a 10 percent increase of the base employment level for plant B. In the year in which the taxpayer elects to take the credit, the employment level at plant A is 290 and at plant B is 120. The credit would be 6 percent of the wages of 10 new employees at plant B as 10 new jobs were created by the industry in the state. A credit for the remaining 10 employees can be taken if the employment level at plant A increases back to 300 during the period of time that the credit can be taken.

42.12(3) *When the credit can be taken.* The taxpayer may elect to take the credit in any tax year which either begins or ends during the period beginning with the date of the agreement and ending with the date by which the project is to be completed under the agreement. However, the taxpayer may not take the credit until the base employment level has been exceeded by at least 10 percent.

EXAMPLE: A taxpayer enters into an agreement to increase employment from a base employment level of 200 employees to 225 employees. In year one of the agreement, the taxpayer hires 20 new employees which is a 10 percent increase over the base employment level but elects not to take the credit. In year two of the agreement, two of the new employees leave employment. The taxpayer elects to take the credit which would be 6 percent of the taxable wages of the 18 employees currently employed. In year three, the taxpayer hires 7 new employees and elects to take the credit. The credit would be 6 percent of the taxable wages of the 7 new employees.

A taxpayer may claim on the taxpayer's individual income tax return the pro rata share of the Iowa new jobs credit from a partnership, subchapter S corporation, estate or trust. The portion of the credit claimed by the individual shall be in the same ratio as the individual's pro rata share of the earnings of the partnership, subchapter S corporation, or estate or trust. All partners in a partnership, shareholders in a subchapter S corporation and beneficiaries in an estate or trust shall elect to take the Iowa new jobs credit the same year.

For tax years beginning prior to January 1, 2007, any Iowa new jobs credit in excess of the individual's tax liability less the credits authorized in Iowa Code sections 422.12 and 422.12B may be carried forward for ten years or until it is used, whichever is the earlier. For tax years beginning on or after January 1, 2007, any Iowa new jobs credit in excess of the individual's tax liability less the credits authorized in Iowa Code section 422.12 may be carried forward for ten years or until it is used, whichever is the earlier.

This rule is intended to implement Iowa Code section 422.11A.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.13(422) Earned income credit.

42.13(1) *Tax years beginning before January 1, 2007.* Effective for tax years beginning on or after January 1, 1990, an individual is allowed an Iowa earned income credit equal to a percentage of the earned income credit to which the taxpayer is entitled on the taxpayer's federal income tax return as authorized in Section 32 of the Internal Revenue Code. The Iowa earned income credit is nonrefundable; therefore, the credit may not exceed the remaining income tax liability of the taxpayer after the personal exemption credits and the other nonrefundable credits are deducted. The percentage of the earned income credit for tax years beginning in the 1990 calendar year is 5 percent. The percentage of the earned income credit for tax years beginning on or after January 1, 1991, is 6.5 percent.

For federal income tax purposes, the earned income credit is available for a low-income worker who maintains a household in the United States that is the principal place of abode of the worker and a child or children for more than one-half of the tax year or the worker must have provided a home for the entire tax year for a dependent parent. In addition, the worker must be (1) a married person who files a joint return and is entitled to a dependency exemption for a son or daughter, adopted child or stepchild; (2) a surviving spouse; or (3) an individual who qualifies as a head of household as described in Section 2(b) of the Internal Revenue Code. The federal earned income credit for a taxpayer is determined by computing the taxpayer's earned income on a worksheet provided in the federal income tax return instructions and determining the allowable credit from a table included in the instructions for the 1040 or 1040A. For purposes of the credit, a taxpayer's earned income includes wages, salaries, tips, or other compensation plus net income from self-employment.

In the case of married taxpayers who filed a joint federal return and who elected to file separate state returns or separately on the combined return form, the Iowa earned income credit is allocated between the spouses in the ratio that each spouse's earned income relates to the earned income of both spouses.

Nonresidents and part-year residents of Iowa are allowed the same earned income credits as resident taxpayers.

42.13(2) *Tax years beginning on or after January 1, 2007.* Effective for tax years beginning on or after January 1, 2007, but beginning before January 1, 2013, an individual is allowed an Iowa earned income credit equal to 7 percent of the earned income credit to which the taxpayer is entitled on the taxpayer's federal income tax return as authorized in Section 32 of the Internal Revenue Code. For tax years beginning on or after January 1, 2013, but beginning before January 1, 2014, an individual is allowed an Iowa earned income tax credit equal to 14 percent of the earned income credit to which the taxpayer is entitled on the taxpayer's federal income tax return as authorized in Section 32 of the Internal Revenue Code. For tax years beginning on or after January 1, 2014, an individual is allowed an Iowa earned income tax credit equal to 15 percent of the earned income credit to which the taxpayer is entitled on the taxpayer's federal income tax return as authorized in Section 32 of the Internal Revenue Code. The Iowa earned income credit is refundable; therefore, the credit may exceed the remaining income tax liability of the taxpayer after the personal exemption credits and other nonrefundable credits are deducted.

In the case of married taxpayers who filed a joint federal return and who elected to file separate state returns or separately on the combined return form, the Iowa earned income credit is allocated between the spouses in the ratio that each spouse's earned income relates to the earned income of both spouses.

Nonresidents or part-year residents of Iowa must determine the Iowa earned income tax credit in the ratio of their Iowa source net income to their total source net income. In addition, if nonresidents or part-year residents of Iowa are married and elect to file separate returns or separately on the combined return form, the Iowa earned income credit must be allocated between the spouses in the ratio of each spouse's Iowa source net income to the combined Iowa source net income.

EXAMPLE: A married couple lives in Omaha, Nebraska. One spouse worked in Iowa in 2007 and had wages and other income from Iowa sources of $12,000. That spouse had a federal adjusted gross income from all sources of $15,000. The other spouse had no Iowa source net income and had a federal adjusted gross income from all sources of $10,000. The taxpayers had a federal earned income credit of $2,800.

The federal earned income credit of $2,800 multiplied by 7 percent equals $196. The ratio of Iowa source net income of $12,000 divided by total source net income of $25,000 equals 48 percent. The Iowa earned income tax credit equals $196 multiplied by 48 percent, or $94.

This rule is intended to implement Iowa Code section 422.12B as amended by 2013 Iowa Acts, Senate File 295.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 1102C**, IAB 10/16/13, effective 11/20/13]

701—42.14(15) Investment tax credit—new jobs and income program and enterprise zone program.

42.14(1) *General rule.* An investment tax credit of up to 10 percent of the new investment which is directly related to new jobs created by the location or expansion of an eligible business is available for businesses approved by the economic development authority under the new jobs and income program and the enterprise zone program. The new jobs and income program was repealed on July 1, 2005, and has been replaced with the high quality job creation program. See rule 701—42.29(15) for information on the investment tax credit under the high quality job creation program. Any investment tax credit earned by businesses approved under the new jobs and income program prior to July 1, 2005, remains valid and can be claimed on tax returns filed after July 1, 2005. The credit is available for machinery and equipment or improvements to real property placed in service after May 1, 1994. The credit shall be taken in the year the qualifying asset is placed in service. The enterprise zone program was repealed on July 1, 2014. Any investment tax credit earned by businesses approved under the enterprise zone program prior to July 1, 2014, remains valid and can be claimed on tax returns filed after July 1, 2014. For business applications received by the economic development authority on or after July 1, 1999, purchases of real property made in conjunction with the location or expansion of an eligible business, the cost of land and any buildings and structures located on the land will be considered to be new investment which is directly related to new jobs for purposes of determining the amount of new investment upon which an investment tax credit may be taken. For projects approved on or after July 1, 2005, under the enterprise

zone program, the investment tax credit will be amortized over a five-year period, as described in subrule 42.29(2).

For eligible businesses approved by the Iowa department of economic development on or after March 17, 2004, certain lease payments made by eligible businesses to a third-party developer will be considered to be new investment for purposes of computing the investment tax credit. The eligible business shall enter into a lease agreement with the third-party developer for a minimum of ten years. The investment tax credit is based on the annual base rent paid to a third-party developer by the eligible business for a period not to exceed ten years. The total costs of the annual base rent payments for the ten-year period cannot exceed the cost of the land and the third-party developer's cost to build or renovate the building used by the eligible business. The annual base rent is defined as the total lease payment less taxes, insurance and operating and maintenance expenses.

Any credit in excess of the tax liability for the tax year may be carried forward seven years or until used, whichever is the earlier.

If the business is a partnership, S corporation, limited liability company, or an estate or trust electing to have the income taxed directly to an individual, an individual may claim the credit. The amount of the credit claimed by the individual must be based on the individual's pro rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

42.14(2) *Investment tax credit—value-added agricultural products or biotechnology-related processes.* For tax years beginning on or after July 1, 2001, an eligible business whose project primarily involves the production of value-added agricultural products may elect to receive a refund for all or a portion of an unused investment tax credit. For tax years beginning on or after July 1, 2001, but before July 1, 2003, an eligible business includes a cooperative described in Section 521 of the Internal Revenue Code which is not required to file an Iowa corporation income tax return and whose project primarily involves the production of ethanol. For tax years beginning on or after July 1, 2003, an eligible business includes a cooperative described in Section 521 of the Internal Revenue Code which is not required to file an Iowa corporation income tax return. For tax years ending on or after July 1, 2005, an eligible business approved under the enterprise zone program whose project primarily involves biotechnology-related processes may elect to receive a refund for all or a portion of an unused investment tax credit.

Eligible businesses shall apply to the Iowa department of economic development for tax credit certificates between May 1 and May 15 of each fiscal year through the fiscal year ending June 30, 2009. The election to receive a refund of all or a portion of an unused investment tax credit is no longer available beginning with the fiscal year ending June 30, 2010. Only those businesses that have completed projects before the May 1 filing date may apply for a tax credit certificate. The Iowa department of economic development will not issue tax credit certificates for more than $4 million during a fiscal year for this program and eligible businesses described in subrule 42.29(2). If applications are received for more than $4 million, the applicants shall receive certificates for a prorated amount.

The economic development authority will issue tax credit certificates within a reasonable period of time. Tax credit certificates are valid for the tax year following project completion. The tax credit certificate must be included with the tax return for the tax year during which the tax credit is claimed. The tax credit certificate shall not be transferred, except for a cooperative described in Section 521 of the Internal Revenue Code which is required to file an Iowa corporation income tax return and whose project primarily involves the production of ethanol for tax years beginning on or after January 1, 2002, or for a cooperative described in Section 521 of the Internal Revenue Code which is required to file an Iowa corporation income tax return for tax years beginning on or after July 1, 2003.

For value-added agricultural projects, for a cooperative that is not required to file an Iowa income tax return because it is exempt from federal income tax, the cooperative must submit a list of its members and the share of each member's interest in the cooperative. The Iowa department of economic development will issue a tax credit certificate to each member on the list.

See 701—subrule 52.10(4) for examples illustrating how this subrule is applied.

For tax years beginning on or after January 1, 2002, but before July 1, 2003, a cooperative described in Section 521 of the Internal Revenue Code which is required to file an Iowa corporation income tax return and whose project primarily involves the production of ethanol may elect to transfer all or a portion of its tax credit to its members. For tax years beginning on or after July 1, 2003, a cooperative described in Section 521 of the Internal Revenue Code which is required to file an Iowa corporation income tax return may elect to transfer all or a portion of its tax credit to its members. The amount of tax credit transferred and claimed by a member shall be based upon the pro rata share of the member's earnings in the cooperative. The economic development authority will issue a tax credit certificate to each member of the cooperative to whom the credit was transferred provided that tax credit certificates which total no more than $4 million are issued during a fiscal year. The tax credit certificate must be included with the tax return for the tax year during which the tax credit is claimed.

42.14(3) *Repayment of credits.* If an eligible business fails to maintain the requirements of the new jobs and income program or the enterprise zone program, the taxpayer may be required to repay all or a portion of the tax incentives taken on Iowa returns. Irrespective of the fact that the statute of limitations to assess the taxpayer for repayment of the tax credits may have expired, the department may proceed to collect the tax incentives forfeited by failure to maintain the requirements of the new jobs and income program or the enterprise zone program because this repayment is a recovery of an incentive, rather than an adjustment to the taxpayer's tax liability. Details on the calculation of the repayment can be found in 261—subrule 187.5(4) of the administrative rules of the economic development authority. If the business is a partnership, limited liability company, S corporation, estate or trust where the income of the taxpayer is taxed to the individual owner(s) of the business, the department may proceed to collect the tax incentives against the partners, members, shareholders or beneficiaries to whom the tax incentives were passed through. See Decision of the Administrative Law Judge in *Damien & Colette Trebilcock, et al.,* Docket No. 11DORF 042-044, June 11, 2012.

If the eligible business, within five years of purchase, sells, disposes of, razes, or otherwise renders unusable all or a part of the land, buildings, or other existing structures for which a tax credit was claimed under this rule, the income tax liability of the eligible business for the year in which all or part of the property is sold, disposed of, razed, or otherwise rendered unusable shall be increased by one of the following amounts:

a. One hundred percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within one full year after being placed in service.

b. Eighty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within two full years after being placed in service.

c. Sixty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within three full years after being placed in service.

d. Forty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within four full years after being placed in service.

e. Twenty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within five full years after being placed in service.

This rule is intended to implement Iowa Code section 15.333 as amended by 2010 Iowa Acts, Senate File 2380.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10; **ARC 1744C**, IAB 11/26/14, effective 12/31/14]

701—42.15(422) Child and dependent care credit. Effective for tax years beginning on or after January 1, 1990, there is a child and dependent care credit which is refundable to the extent the amount of the credit exceeds the taxpayer's income tax liability less other applicable income tax credits.

42.15(1) *Computation of the Iowa child and dependent care credit.* The Iowa child and dependent care credit is computed as a percentage of the child and dependent care credit which is allowed for federal income tax purposes under Section 21 of the Internal Revenue Code. For taxpayers whose federal child and dependent care credit is limited to their federal tax liability, the Iowa credit shall be computed based on the lesser amount for tax years beginning on or after January 1, 2012, but before January 1,

2015. For tax years beginning on or after January 1, 2015, the Iowa credit is computed without regard to whether or not the federal credit was limited to the taxpayer's federal tax liability. In addition, for tax years beginning on or after January 1, 2015, the Iowa credit will be allowed even if the taxpayer's adjusted gross income is below $0. The credit is computed so that taxpayers with lower adjusted gross incomes (net incomes in tax years beginning on or after January 1, 1991) are allowed higher percentages of their federal child care credit than taxpayers with higher adjusted gross incomes (net incomes). The following is a schedule showing the percentages of federal child and dependent care credits allowed on the taxpayers' Iowa returns on the basis of the federal adjusted gross incomes (or net incomes) of the taxpayers for tax years beginning on or after January 1, 1993.

*Federal Adjusted Gross Income (Net Income for Tax Years Beginning on or after January 1, 1993)	Percentage of Federal Child and Dependent Care Credit Allowed for 1993 through 2005 Iowa Returns	Percentage of Federal Credit Allowed for 2006 and Later Tax Years
Less than $10,000	75%	75%
$10,000 or more but less than $20,000	65%	65%
$20,000 or more but less than $25,000	55%	55%
$25,000 or more but less than $35,000	50%	50%
$35,000 or more but less than $40,000	40%	40%
$40,000 or more but less than $45,000	No Credit	30%
$45,000 or more	No Credit	No Credit

*Note that in the case of married taxpayers who have filed joint federal returns and elect to file separate returns or separately on the combined return form, the taxpayers must determine the child and dependent care credit by the schedule provided in this rule on the basis of the combined federal adjusted gross income of the taxpayers or their combined net income for tax years beginning on or after January 1, 1991. The credit determined from the schedule must be allocated between the married taxpayers in the proportion that each spouse's federal adjusted gross income relates to the combined federal adjusted gross income of the taxpayers or in the proportion that each spouse's net income relates to the combined net income of the taxpayers in the case of tax years beginning on or after January 1, 1991.

42.15(2) *Examples of computation of the Iowa child and dependent care credit.* The following are examples of computation of the child and dependent care credit and the allocation of the credit between spouses in situations where married taxpayers have filed joint federal returns and are filing separate Iowa returns or separately on the combined return form. For tax years beginning on or after January 1, 1991, the taxpayers' net incomes are used to compute the Iowa child and dependent care credit and allocate the credit between spouses in situations where the taxpayers file separate Iowa returns or separately on the combined return form.

EXAMPLE A. A married couple has filed a joint federal return on which they showed a federal adjusted gross income of $40,000 or a combined net income of $40,000 on their state return for the tax year beginning January 1, 2007. Both spouses were employed. They had a federal child and dependent care credit of $600 which related to expenses incurred for care of their two small children. One of the spouses had a federal adjusted gross income of $30,000 or a net income of $30,000 and the second spouse had a federal adjusted gross income of $10,000 or a net income of $10,000.

The taxpayers' Iowa child and dependent care credit was $180 since they were entitled to an Iowa child and dependent care credit of 30 percent of their federal credit of $600. If the taxpayers elect to file separate Iowa returns, the $180 credit would be allocated between the spouses on the basis of each spouse's net income to the combined net income of both spouses as shown below:

$$\$180 \times \frac{\$30{,}000}{\$40{,}000} = \$135$$ child and dependent care credit for spouse with $30,000 net income for 2007

$$\$180 \times \frac{\$10{,}000}{\$40{,}000} = \$45$$ child and dependent care credit for spouse with $10,000 net income for 2007

EXAMPLE B. A married couple filed a joint federal return for 2007 and filed their 2007 Iowa return using the married filing separately on the combined return form filing status. Both spouses were employed. They had a federal child and dependent care credit of $800 which related to expenses incurred for care of their children. One spouse had a net income of $25,000 and the other spouse had a net income of $12,500.

The taxpayers' Iowa child and dependent care credit was $320, since they were entitled to an Iowa credit of 40 percent of their federal credit of $800. The $320 credit is allocated between the spouses on the basis of each spouse's net income as it relates to the combined net income of both spouses as shown below:

$$\$320 \times \frac{\$25{,}000}{\$37{,}500} = \$213$$ child and dependent care credit for spouse with $25,000 net income for 2007

$$\$320 \times \frac{\$12{,}500}{\$37{,}500} = \$107$$ child and dependent care credit for spouse with $12,500 net income for 2007

42.15(3) *Computation of the Iowa child and dependent care credit for nonresidents and part-year residents.* Nonresidents and part-year residents who have incomes from Iowa sources in the tax year may claim child and dependent care credits on their Iowa returns. To compute the amount of child and dependent care credit that can be claimed on the Iowa return by a nonresident or part-year resident, the following formula shall be used:

$$\text{Federal child and dependent care credit} \times \text{Percentage of federal child and dependent credit allowed on Iowa return from table in subrule 42.15(1)} \times \frac{\text{*Iowa net income}}{\text{Federal adjusted gross income or all source net income}}$$

*Iowa net income for purposes of determining the child care credit that can be claimed on the Iowa return by a nonresident or part-year resident taxpayer is the total of the Iowa source incomes less the Iowa source adjustments to income on line 26 of the Form IA 126.

In cases where married taxpayers are nonresidents or part-year residents of Iowa and are filing separate Iowa returns or separately on the combined return form, the child and dependent care credit allowable on the Iowa return should be allocated between the spouses in the ratio of the Iowa net income of each spouse to the combined Iowa net income of the taxpayers.

42.15(4) *Example of computation of the Iowa child and dependent care credit for nonresidents and part-year residents.* The following is an example of the computation of the Iowa child and dependent care credit for nonresidents and part-year residents.

A married couple lives in Omaha, Nebraska. One of the spouses worked in Iowa and had wages and other income from Iowa sources or an Iowa net income of $15,000. That spouse had an all source net income of $18,000. The second spouse had an Iowa net income of $10,000 and an all source net income of $12,000. The taxpayers had a federal child and dependent care credit of $800 which related to expenses incurred for the care of their two young children. The taxpayers' Iowa child and dependent care credit is calculated below for the 2007 tax year:

Federal child and dependent care credit		Percentage of federal child and dependent credit allowed on Iowa return		Iowa net income / All source net income		
$800	×	50%	=	$400 ×	$25,000 / $30,000 =	$333

The $333 credit is allocated between the spouses as shown below for the 2007 tax year:

$333 × $10,000 / $25,000 = $133 for spouse with Iowa source net income of $10,000

$333 × $15,000 / $25,000 = $200 for spouse with Iowa source net income of $15,000

This rule is intended to implement Iowa Code section 422.12C as amended by 2014 Iowa Acts, Senate File 2337.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 0337C**, IAB 9/19/12, effective 10/24/12; **ARC 1665C**, IAB 10/15/14, effective 11/19/14]

701—42.16(422) Franchise tax credit. For tax years beginning on or after January 1, 1997, a shareholder in a financial institution, as defined in Section 581 of the Internal Revenue Code, which has elected to have its income taxed directly to the shareholders may take a tax credit equal to the shareholder's pro rata share of the Iowa franchise tax paid by the financial institution.

For tax years beginning on or after July 1, 2004, a member of a financial institution organized as a limited liability company that is taxed as a partnership for federal income tax purposes which has elected to have its income taxed directly to its members may take a tax credit equal to the member's pro rata share of the Iowa franchise tax paid by the financial institution.

The credit must be computed by recomputing the amount of tax computed under Iowa Code section 422.5 by reducing the shareholder's or member's taxable income by the shareholder's or member's pro rata share of the items of income and expenses of the financial institution and subtracting the credits allowed in Iowa Code sections 422.12 and 422.12B for tax years beginning prior to January 1, 2007. The recomputed tax must be subtracted from the amount of tax computed under Iowa Code section 422.5 reduced by the credits allowed in Iowa Code sections 422.12 and 422.12B for tax years beginning prior to January 1, 2007. For tax years beginning on or after January 1, 2007, only the credits allowed in Iowa Code section 422.12 are reduced in computing the franchise tax credit.

The resulting amount, not to exceed the shareholder's or member's pro rata share of the franchise tax paid by the financial institution, is the amount of tax credit allowed the shareholder or member.

This rule is intended to implement Iowa Code section 422.11.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.17(15E) Eligible housing business tax credit. An individual who qualifies as an eligible housing business may receive a tax credit of up to 10 percent of the new investment which is directly related to the building or rehabilitating of homes in an enterprise zone. The enterprise zone program was repealed on July 1, 2014, and the eligible housing business tax credit has been replaced with the workforce housing tax incentives program. See rule 701—42.53(15) for information on the tax incentives provided under the workforce housing tax incentives program. Any investment tax credit earned by businesses approved under the enterprise zone program prior to July 1, 2014, remains valid and can be claimed on tax returns filed after July 1, 2014. The tax credit may be taken on the tax return for the tax year in which the home is ready for occupancy.

An eligible housing business is one which meets the criteria in 2014 Iowa Code section 15E.193B.

42.17(1) *Computation of credit.* New investment which is directly related to the building or rehabilitating of homes includes but is not limited to the following costs: land, surveying, architectural services, building permits, inspections, interest on a construction loan, building materials, roofing, plumbing materials, electrical materials, amounts paid to subcontractors for labor and materials provided, concrete, labor, landscaping, appliances normally provided with a new home, heating and cooling equipment, millwork, drywall and drywall materials, nails, bolts, screws, and floor coverings.

New investment does not include the machinery, equipment, or hand or power tools necessary to build or rehabilitate homes.

A taxpayer may claim on the taxpayer's individual income tax return the pro rata share of the Iowa eligible housing business tax credit from a partnership, S corporation, limited liability company, estate, or trust. The portion of the credit claimed by the individual shall be in the same ratio as the individual's pro rata share of the earnings of the partnership, S corporation, limited liability company, or estate or trust, except for projects beginning on or after July 1, 2005, which used low-income housing tax credits authorized under Section 42 of the Internal Revenue Code to assist in the financing of the housing development. For these projects, the partnership, limited liability company or S corporation may designate the amount of the tax credit to be allocated to each partner, member or shareholder.

For tax years beginning prior to January 1, 2007, any Iowa eligible housing business tax credit in excess of the individual's tax liability, less the credits authorized in Iowa Code sections 422.12 and 422.12B, may be carried forward for seven years or until it is used, whichever is the earlier. For tax years beginning on or after January 1, 2007, any Iowa eligible housing business tax credit in excess of the individual's tax liability less the credits authorized in Iowa Code section 422.12 may be carried forward for seven years or until it is used, whichever is the earlier.

If the eligible housing business fails to maintain the requirements of 2014 Iowa Code section 15E.193B, the taxpayer, in order to be an eligible housing business, may be required to repay all or a part of the tax incentives the taxpayer received. Irrespective of the fact that the statute of limitations to assess the taxpayer for repayment of the income tax credit may have expired, the department may proceed to collect the tax incentives forfeited by failure to maintain the requirements of 2014 Iowa Code section 15E.193B. This repayment is required because it is a recovery of an incentive, rather than an adjustment to the taxpayer's tax liability. Details on the calculation of the repayment can be found in 261—subrule 187.5(4) of the administrative rules of the economic development authority. If the business is a partnership, limited liability company, S corporation, estate or trust where the income of the taxpayer is taxed to the individual owner(s) of the business, the department may proceed to collect the tax incentives against the partners, members, shareholders or beneficiaries to whom the tax incentives were passed through. See Decision of the Administrative Law Judge in *Damien & Colette Trebilcock, et al.,* Docket No. 11DORF 042-044, June 11, 2012.

Prior to January 1, 2001, the tax credit cannot exceed 10 percent of $120,000 for each home or individual unit in a multiple dwelling unit building. Effective January 1, 2001, the tax credit cannot exceed 10 percent of $140,000 for each home or individual unit in a multiple dwelling unit building.

Effective for tax periods beginning on or after January 1, 2003, the taxpayer must receive a tax credit certificate from the economic development authority to claim the eligible housing business tax credit. The tax credit certificate shall include the taxpayer's name, the taxpayer's address, the taxpayer's tax identification number, the date the project was completed, the amount of the eligible housing business tax credit and the tax year for which the credit may be claimed. In addition, the tax credit certificate shall include a place for the name and tax identification number of a transferee and the amount of the tax credit being transferred, as provided in subrule 42.17(2). The tax credit certificate must be included with the income tax return for the tax period in which the home is ready for occupancy. The administrative rules for the eligible housing business tax credit for the economic development authority may be found under 261—Chapter 59.

42.17(2) *Transfer of the eligible housing business tax credit.* For tax periods beginning on or after January 1, 2003, the eligible housing business tax credit certificates may be transferred to any person or entity if low-income housing tax credits authorized under Section 42 of the Internal Revenue Code are

used to assist in the financing of the housing development. In addition, the eligible housing business tax credit certificates may be transferred to any person or entity for projects beginning on or after July 1, 2005, if the housing development is located in a brownfield site as defined in Iowa Code section 15.291, or if the housing development is located in a blighted area as defined in Iowa Code section 403.17. No more than $3 million of tax credits for housing developments located in brownfield sites or blighted areas may be transferred in a calendar year, with no more than $1.5 million being transferred for any one eligible housing business in a calendar year.

The excess of the $3 million limitation of tax credits eligible for transfer in the 2013 and 2014 calendar years for housing developments located in brownfield sites or blighted areas cannot be claimed by a transferee prior to January 1, 2016. The eligible housing business must have notified the economic development authority in writing before July 1, 2014, of the business's intent to transfer any tax credits for housing developments located in brownfield sites or blighted areas. If a tax credit certificate is issued by the economic development authority for a housing development approved prior to July 1, 2014, that is located in a brownfield site or blighted area, the tax credit can still be claimed by the eligible business, but the tax credit cannot be transferred by the eligible business if the economic development authority was not notified prior to July 1, 2014.

EXAMPLE 1: A housing development located in a brownfield site was completed in December 2013 and was issued a tax credit certificate totaling $250,000. The $3 million calendar cap for transferred tax credits for brownfield sites and blighted areas has already been reached for the 2013 and 2014 tax years. The $250,000 tax credit is going to be transferred to Bill Smith, and the economic development authority was notified of the transfer prior to July 1, 2014. Once a replacement tax credit certificate has been issued, Mr. Smith cannot file an amended Iowa individual income tax return for the 2013 tax year until January 1, 2016, to claim the $250,000 tax credit.

EXAMPLE 2: A housing development located in a blighted area was completed in May 2014 and was issued a tax credit certificate totaling $150,000. The $3 million calendar cap for transferred tax credits for brownfield sites and blighted areas has already been reached for the 2014 tax year. The $150,000 tax credit is going to be transferred to Greg Rogers, and the economic development authority was notified of the transfer prior to July 1, 2014. Once a replacement tax credit certificate has been issued, Mr. Rogers cannot file an amended Iowa individual income tax return for the 2014 tax year until January 1, 2016, to claim the $150,000 tax credit.

Within 90 days of transfer of the tax credit certificate for transfers prior to July 1, 2006, the transferee must submit the transferred tax credit certificate to the economic development authority, along with a statement which contains the transferee's name, address and tax identification number and the amount of the tax credit being transferred. For transfers on or after July 1, 2006, the transferee must submit the transferred tax credit certificate to the department of revenue. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee for transfers prior to July 1, 2006, the economic development authority will issue a replacement tax credit certificate to the transferee. For transfers on or after July 1, 2006, the department of revenue will issue the replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company or S corporation, the transferee shall provide a list of the partners, members or shareholders and information on how the housing business tax credit should be divided among the partners, members or shareholders. The transferee shall also provide the tax identification numbers and addresses of the partners, members or shareholders. The replacement tax credit certificate must contain the same information that was on the original certificate and must have the same expiration date as the original tax credit certificate.

The transferee may use the amount of the tax credit for any tax period for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credits shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

This rule is intended to implement 2014 Iowa Code section 15E.193B.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 1744C**, IAB 11/26/14, effective 12/31/14]

701—42.18(422) Assistive device tax credit. Effective for tax years beginning on or after January 1, 2000, a taxpayer that is a small business that purchases, rents, or modifies an assistive device or makes workplace modifications for an individual with a disability who is employed or will be employed by the taxpayer may qualify for an assistive device tax credit, subject to the availability of the credit. The assistive device credit is equal to 50 percent of the first $5,000 paid during the tax year by the small business for the purchase, rental, or modification of an assistive device or for making workplace modifications. Any credit in excess of the tax liability may be refunded or applied to the taxpayer's tax liability for the following tax year. If the taxpayer elects to take the assistive device tax credit, the taxpayer shall not deduct for Iowa income tax purposes any amount of the cost of an assistive device or workplace modification that is deductible for federal income tax purposes. A small business will not be eligible for the assistive device credit if the device is provided for an owner of the small business unless the owner is a bona fide employee of the small business.

42.18(1) *Submitting applications for the credit.* A small business that wishes to receive the assistive device tax credit must submit an application for the credit to the Iowa department of economic development and provide other information and documents requested by the Iowa department of economic development. If the taxpayer meets the criteria for qualification for the credit, the Iowa department of economic development will issue the taxpayer a certificate of entitlement for the credit. However, the aggregate amount of assistive device tax credits that may be granted by the Iowa department of economic development to all small businesses during a fiscal year cannot exceed $500,000. The certificate of entitlement for the assistive device credit shall include the taxpayer's name, the taxpayer's address, the taxpayer's tax identification number, the estimated amount of the tax credit, the date on which the taxpayer's application was approved, the date when it is anticipated that the assistive device project will be completed and a space on the application where the taxpayer shall enter the date that the assistive device project was completed. The certificate of entitlement will not be considered to be valid for purposes of claiming the assistive device credit on the taxpayer's Iowa income tax return until the taxpayer has completed the assistive device project and has entered the completion date on the certificate of entitlement form. The tax year of the small business in which the assistive device project is completed is the tax year for which the assistive device credit may be claimed. For example, in a case where taxpayer A received a certificate of entitlement for an assistive device credit on September 15, 2007, and completed the assistive device workplace modification project on January 15, 2008, taxpayer A could claim the assistive device credit on taxpayer A's 2008 Iowa return, assuming that taxpayer A is filing returns on a calendar-year basis.

The department of revenue will not allow the assistive device credit on a taxpayer's return if the certificate of entitlement or a legible copy of the certificate is not included with the taxpayer's income tax return. If the taxpayer has been granted a certificate of entitlement and the taxpayer is a partnership, limited liability company, S corporation, estate, or trust, where the income of the taxpayer is taxed to the individual owner(s) of the business entity, the taxpayer must provide a copy of the certificate to each of the owners with a statement showing how the credit is to be allocated among the individual owners of the business entity. An individual owner shall include a copy of the certificate of entitlement and the statement of allocation of the assistive device credit with the individual's state income tax return.

42.18(2) *Definitions.* The following definitions are applicable to this rule:

"Assistive device" means any item, piece of equipment, or product system which is used to increase, maintain, or improve the functional capabilities of an individual with a disability in the workplace or on the job. "Assistive device" does not mean any medical device, surgical device, or organ implanted or transplanted into or attached directly to an individual. "Assistive device" does not include any device for which a certificate of title is issued by the state department of transportation, but does include any item, piece of equipment, or product system otherwise meeting the definition of "assistive device" that is incorporated, attached, or included as a modification in or to such a device issued a certificate of title.

"Business entity" means partnership, limited liability company, S corporation, estate, or trust, where the income of the business is taxed to each of the individual owners of the business, whether the individual owner is a partner, member, shareholder, or beneficiary.

"Disability" means the same as defined in Iowa Code section 15.102. Therefore, "disability" means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of the individual, a record of physical or mental impairment that substantially limits one or more of the major life activities of the individual, or being regarded as an individual with a physical or mental impairment that substantially limits one or more of the major life activities of the individual. "Disability" does not include any of the following:

1. Homosexuality or bisexuality.
2. Transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders, or other sexual behavior disorders.
3. Compulsive gambling, kleptomania, or pyromania.
4. Psychoactive substance abuse disorders resulting from current illegal use of drugs.
5. Alcoholism.

"Employee" means an individual who is employed by the small business and who meets the criteria in Treasury Regulation § 31.3401(c)-1(b), which is the definition of an employee for federal income tax withholding purposes. An individual who receives self-employment income from the small business shall not be considered an employee of the small business for purposes of this rule.

"Small business" means that the business either had gross receipts in the tax year before the current tax year of $3 million or less or employed not more than 14 full-time employees during the tax year prior to the current tax year.

"Workplace modifications" means physical alterations to the office, factory, or other work environment where the disabled employee is working or will work.

42.18(3) *Allocation of assistive tax credit to owners of a business entity.* If the taxpayer that was entitled to an assistive device credit is a business entity, the business entity shall allocate the allowable credit to each of the individual owners of the entity on the basis of each owner's pro rata share of the earnings of the entity to the total earnings of the entity. Therefore, if a partnership has an assistive device credit of $2,500 for a tax year and one partner of the partnership receives 25 percent of the earnings of the partnership, that partner would receive an assistive device credit for the tax year of $625 or 25 percent of the total assistive device credit of the partnership.

42.18(4) *Repeal of credit.* The assistive device credit is repealed on July 1, 2009.

This rule is intended to implement Iowa Code section 422.11E.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 1744C**, IAB 11/26/14, effective 12/31/14]

701—42.19(404A,422) Historic preservation and cultural and entertainment district tax credit for projects with Part 2 applications approved and tax credits reserved prior to July 1, 2014. A historic preservation and cultural and entertainment district tax credit, subject to the availability of the credit, may be claimed against a taxpayer's Iowa individual income tax liability for 25 percent of the qualified costs of rehabilitation of property to the extent the costs were incurred on or after July 1, 2000, for approved rehabilitation projects of eligible property in Iowa.

The general assembly has mandated that the department of cultural affairs and the department of revenue adopt rules to jointly administer Iowa Code chapter 404A. 2014 Iowa Acts, House File 2453, amended the historic preservation and cultural and entertainment district tax credit program effective July 1, 2014. The department of revenue's provisions for projects with tax credits reserved prior to July 1, 2014, are found in this rule. The department of revenue's provisions for projects with agreements entered into on or after July 1, 2014, are found in rule 701—42.54(404A,422). The department of cultural affairs' rules related to this program may be found at 223—Chapter 48. Division I of 223—Chapter 48 applies to projects with reservations approved prior to July 1, 2014. Division II of 223—Chapter 48 applies to projects with agreements entered into on or after July 1, 2014.

Notwithstanding anything contained herein to the contrary, the department of cultural affairs shall not reserve tax credits under 2013 Iowa Code chapter 404A as amended by 2013 Iowa Acts, chapter 112, section 1, for applicants that do not have an approved Part 2 application and a tax credit reservation on or before June 30, 2014. Projects with approved Part 2 applications and provisional tax credit reservations on or before June 30, 2014, shall be governed by 2013 Iowa Code chapter 404A as amended by 2013

Iowa Acts, chapter 112, section 1; by 223—Chapter 48, Division I; and by rule 701—42.19(404A,422). Projects for which Part 2 applications were approved and agreements entered into after June 30, 2014, shall be governed by 2014 Iowa Acts, House File 2453; by 223—Chapter 48, Division II; and by rule 701—42.54(404A,422).

42.19(1) *Eligible properties for the historic preservation and cultural and entertainment district tax credit.* The following types of property are eligible for the historic preservation and cultural and entertainment district tax credit:

a. Property verified as listed on the National Register of Historic Places or eligible for such listing.

b. Property designated as of historic significance to a district listed in the National Register of Historic Places or eligible for such designation.

c. Property or district designated a local landmark by a city or county ordinance.

d. Any barn constructed prior to 1937.

42.19(2) *Application and review process for the historic preservation and cultural and entertainment district tax credit.*

a. Taxpayers who want to claim an income tax credit for completing a historic preservation and cultural and entertainment district project must submit an application for approval of the project. The application forms for the historic preservation and cultural and entertainment district tax credit may be requested from the State Tax Credit Program Manager, State Historic Preservation Office, Department of Cultural Affairs, 600 E. Locust, Des Moines, Iowa 50319-0290. The telephone number for this office is (515)281-4137. Applications for the credit will be accepted by the state historic preservation office on or after July 1, 2000, until such time as all the available credits allocated for each fiscal year are encumbered.

b. Applicants for the historic preservation and cultural and entertainment district tax credit must include all information and documentation requested on the application forms for the credit in order for the application to be processed.

42.19(3) *Computation of the amount of the historic preservation and cultural and entertainment district tax credit.* The amount of the historic preservation and cultural and entertainment district tax credit is 25 percent of the qualified rehabilitation costs made to an eligible property in a project. Qualified rehabilitation costs are those rehabilitation costs approved by the state historic preservation office for a project for a particular taxpayer to the extent those rehabilitation costs are actually expended by that taxpayer.

a. In the case of commercial property, qualified rehabilitation costs must equal at least $50,000 or 50 percent of the assessed value of the property, excluding the value of the land, prior to rehabilitation, whichever is less. In the case of property other than commercial property, the qualified rehabilitation costs must equal at least $25,000 or 25 percent of the assessed value, excluding the value of the land, prior to the rehabilitation, whichever amount is less.

b. In computing the tax credit, the only costs which may be included are the qualified rehabilitation costs incurred commencing from the date on which the first qualified rehabilitation cost is incurred and ending with the end of the taxable year in which the property is placed in service. The rehabilitation period may include dates that precede approval of a project, provided that any qualified rehabilitation costs incurred prior to the date of approval of the project are qualified rehabilitation costs.

c. For purposes of the historic preservation and cultural and entertainment district tax credit, qualified rehabilitation costs include those costs properly included in the basis of the eligible property for income tax purposes. Costs treated as expenses and deducted in the year paid or incurred and amounts that are otherwise not added to the basis of the property for income tax purposes are not qualified rehabilitation costs. Amounts incurred for architectural and engineering fees, site survey fees, legal expenses, insurance premiums, development fees, and other construction-related costs are qualified rehabilitation costs to the extent they are added to the basis of the eligible property for tax purposes. Costs of sidewalks, parking lots, and landscaping do not constitute qualified rehabilitation costs. Any rehabilitation costs used in the computation of the historic preservation and cultural and entertainment district tax credit are not added to the basis of the property for Iowa income tax purposes if the rehabilitation costs were incurred in a tax year beginning on or after January 1, 2000, but prior

to January 1, 2001. Any rehabilitation costs incurred in a tax year beginning on or after January 1, 2001, are added to the basis of the rehabilitated property for income tax purposes except those rehabilitation expenses that are equal to the amount of the computed historic preservation and cultural and entertainment district tax credit for the tax year.

EXAMPLE: The basis of a commercial building in a historic district was $500,000, excluding the value of the land, before the rehabilitation project. During a project to rehabilitate this building, $600,000 in rehabilitation costs were expended to complete the project and $500,000 of those rehabilitation costs were qualified rehabilitation costs which were eligible for the historic preservation and cultural and entertainment district tax credit of $125,000. Therefore, the basis of the building for Iowa income tax purposes was $975,000, since the qualified rehabilitation costs of $125,000, which are equal to the amount of the historic preservation and cultural and entertainment district tax credit for the tax year, are not added to the basis of the rehabilitated property. The basis of the building for federal income tax purposes was $1,100,000. It should be noted that this example does not consider any possible reduced basis for the building for federal income tax purposes due to the rehabilitation investment credit provided in Section 47 of the Internal Revenue Code.

42.19(4) *Completion of the historic preservation and cultural and entertainment district project and claiming the historic preservation and cultural and entertainment district tax credit on the Iowa return.* After the taxpayer completes an authorized rehabilitation project, the taxpayer must be issued a certificate of completion of the project from the state historic preservation office of the department of cultural affairs. After verifying the taxpayer's eligibility for the historic preservation and cultural and entertainment district tax credit, the state historic preservation office shall issue a historic preservation and cultural and entertainment district tax credit certificate, which shall be included with the taxpayer's income tax return for the tax year in which the rehabilitation project is completed or the year the credit was reserved, whichever is later. For example, if a project was completed in 2008 and the credit was reserved for the state fiscal year ending June 30, 2010, the credit can be claimed on the 2009 calendar year return that is due on April 30, 2010. The tax credit certificate shall include the taxpayer's name, the taxpayer's address, the taxpayer's tax identification number, the address or location of the rehabilitation project, the date the project was completed, the year the tax credit was reserved and the amount of the historic preservation and cultural and entertainment district tax credit. In addition, the tax credit certificate shall include a place for the name and tax identification number of a transferee, the amount of the tax credit being transferred, and any consideration received in exchange for the tax credit, as provided in subrule 42.19(6). In addition, if the taxpayer is a partnership, limited liability company, estate or trust, where the tax credit is allocated to the owners or beneficiaries of the entity, a list of the owners or beneficiaries and the amount of credit allocated to each owner or beneficiary shall be provided with the certificate. The tax credit certificate shall be included with the income tax return for the period in which the project was completed.

For tax years ending on or after July 1, 2007, any historic preservation and cultural and entertainment district tax credit in excess of the taxpayer's tax liability is fully refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

42.19(5) *Allocation of historic preservation and cultural and entertainment district tax credits to the individual owners of the entity for tax credits reserved for fiscal years beginning on or after July 1, 2012.* For tax credits reserved for fiscal years beginning on or after July 1, 2012, the partnership, limited liability company or S corporation may designate the amount of the tax credit to be allocated to each partner, member or shareholder. The credit does not have to be allocated based on the pro rata share of earnings of the partnership, limited liability company or S corporation.

42.19(6) *Transfer of the historic preservation and cultural and entertainment district tax credit.* For tax periods beginning on or after January 1, 2003, the historic preservation and cultural and entertainment district tax credit certificates may be transferred to any person or entity. A tax credit certificate of less than $1,000 shall not be transferable.

a. For transfers on or after July 1, 2006, the department of revenue will issue the replacement tax credit certificate to the transferee. Within 90 days of the transfer of the tax credit certificate, the

transferee must submit the transferred tax credit certificate to the department of revenue along with a statement containing the transferee's name, tax identification number and address, the denomination that each replacement tax credit certificate is to carry, the amount of all consideration provided in exchange for the tax credit and the names of recipients of any consideration provided in exchange for the tax credit. If a payment of money was any part of the consideration provided in exchange for the tax credit, the transferee shall list the amount of the payment of money in its statement to the department of revenue. If any part of the consideration provided in exchange for the tax credit included nonmonetary consideration, including but not limited to any promise, representation, performance, discharge of debt or nonmonetary rights or property, the tax credit transferee shall describe the nature of nonmonetary consideration and disclose any value the transferor and transferee assigned to the nonmonetary consideration. The tax credit transferee must indicate on its statement to the department of revenue if no consideration was provided in exchange for the tax credit. If the transferee is a partnership, limited liability company or S corporation, the transferee shall provide a list of the partners, members or shareholders and information on how the historic preservation and cultural and entertainment district tax credit should be divided among the partners, members or shareholders. The transferee shall also provide the tax identification numbers and addresses of the partners, members or shareholders. The replacement tax credit certificate must contain the same information that was on the original certificate and must have the same expiration date as the original tax credit certificate.

b. The transferee may use the amount of the tax credit for any tax period for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

c. If the historic preservation and cultural and entertainment district tax credit of the transferee exceeds the tax liability shown on the transferee's return, the tax credit shall be fully refundable.

This rule is intended to implement Iowa Code chapter 404A as amended by 2013 Iowa Acts, Senate File 436, and Iowa Code section 422.11D.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10; **ARC 9876B**, IAB 11/30/11, effective 1/4/12; **ARC 0398C**, IAB 10/17/12, effective 11/21/12; **ARC 1138C**, IAB 10/30/13, effective 12/4/13; **ARC 1968C**, IAB 4/15/15, effective 5/20/15]

701—42.20(422) Ethanol blended gasoline tax credit. Effective for tax years beginning on or after January 1, 2002, a retail gasoline dealer may claim an ethanol blended gasoline tax credit against that individual's individual income tax liability. The taxpayer must operate at least one retail motor fuel site at which more than 60 percent of the total gallons of gasoline sold and dispensed through one or more motor fuel pumps by the taxpayer in the tax year is ethanol blended gasoline. The tax credit shall be calculated separately for each retail motor fuel site operated by the taxpayer. The amount of the credit for each eligible retail motor fuel site is two and one-half cents multiplied by the total number of gallons of ethanol blended gasoline sold and dispensed through all motor fuel pumps located at that retail motor fuel site during the tax year in excess of 60 percent of all gasoline sold and dispensed through motor fuel pumps at that retail motor fuel site during the tax year.

For taxpayers having a fiscal year ending in 2002, the tax credit is available for each eligible retail motor fuel site based on the total number of gallons of ethanol blended gasoline sold and dispensed through all motor fuel pumps located at the taxpayer's retail motor fuel site from January 1, 2002, until the end of the taxpayer's fiscal year. Assuming a tax period that began on July 1, 2001, and ended on June 30, 2002, the taxpayer would be eligible for the tax credit based on the gallons of ethanol blended gasoline sold from January 1, 2002, through June 30, 2002. For taxpayers having a fiscal year ending in 2002, a claim for refund to claim the ethanol blended gasoline tax credit must be filed before October 1, 2003, even though the statute of limitations for refund set forth in 701—subrule 43.3(8) has not yet expired.

EXAMPLE 1: A taxpayer sold 100,000 gallons of gasoline at the taxpayer's retail motor fuel site during the tax year, 70,000 gallons of which was ethanol blended gasoline. The taxpayer is eligible for the credit since more than 60 percent of the total gallons sold was ethanol blended gasoline. The number

of gallons in excess of 60 percent of all gasoline sold is 70,000 less 60,000, or 10,000 gallons. Two and one-half cents multiplied by 10,000 equals a $250 credit available.

The credit may be calculated on Form IA 6478. The credit must be calculated separately for each retail motor fuel site operated by the taxpayer. Therefore, if the taxpayer operates more than one retail motor fuel site, it is possible that one retail motor fuel site may be eligible for the credit while another retail motor fuel site may not. The credit may be taken only for those retail motor fuel sites for which more than 60 percent of gasoline sales involves ethanol blended gasoline.

Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

Starting with the 2006 calendar tax year, a taxpayer may claim the ethanol blended gasoline tax credit even if the taxpayer also claims the E-85 gasoline promotion tax credit provided in rule 701—42.31(422) for the same tax year for the same ethanol gallons.

EXAMPLE 2: A taxpayer sold 200,000 gallons of gasoline at a retail motor fuel site in 2006, of which 160,000 gallons was ethanol blended gasoline. Of these 160,000 gallons, 1,000 gallons was E-85 gasoline. Taxpayer is entitled to claim the ethanol blended gasoline tax credit of two and one-half cents multiplied by 40,000 gallons, since this amount constitutes the gallons in excess of 60 percent of the total gasoline gallons sold. Taxpayer may also claim the E-85 gasoline promotion tax credit on the 1,000 gallons of E-85 gasoline sold.

42.20(1) *Definitions.* The following definitions are applicable to this rule:

"Ethanol blended gasoline" means the same as defined in Iowa Code section 214A.1.

"Gasoline" means any liquid product prepared, advertised, offered for sale or sold for use as, or commonly and commercially used as, motor fuel for use in a spark-ignition, internal combustion engine, and which meets the specifications provided in Iowa Code section 214A.2.

"Motor fuel pump" means a pump, meter, or similar commercial weighing and measuring device used to measure and dispense motor fuel for sale on a retail basis.

"Retail dealer" means a person engaged in the business of storing and dispensing motor fuel from a motor fuel pump for sale on a retail basis, regardless of whether the motor fuel pump is located at a retail motor fuel site including a permanent or mobile location.

"Retail motor fuel site" means a geographic location in Iowa where a retail dealer sells and dispenses motor fuel on a retail basis. For example, tank wagons are considered retail motor fuel sites.

"Sell" means to sell on a retail basis.

42.20(2) *Allocation of credit to owners of a business entity.* If the taxpayer that was entitled to the ethanol blended gasoline tax credit is a partnership, limited liability company, S corporation, estate, or trust, the business entity shall allocate the allowable credit to each of the individual owners of the entity on the basis of each owner's pro rata share of the earnings of the entity to the total earnings of the entity. Therefore, if a partnership has an ethanol blended gasoline tax credit of $3,000 and one partner of the partnership receives 25 percent of the earnings of the partnership, that partner would receive an ethanol blended gasoline tax credit for the tax year of $750 or 25 percent of the total ethanol blended gasoline tax credit of the partnership.

42.20(3) *Repeal of ethanol blended gasoline tax credit.* The ethanol blended gasoline tax credit is repealed on January 1, 2009. However, the tax credit is available for taxpayers whose fiscal year ends after December 31, 2008, for those ethanol gallons sold beginning on the first day of the taxpayer's fiscal year until December 31, 2008. The ethanol promotion tax credit described in rule 701—42.37(15,422) is available beginning January 1, 2009, for retail dealers of gasoline.

See 701—subrule 52.19(3) for an example illustrating how this subrule is applied.

This rule is intended to implement Iowa Code section 422.11C.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.21(15E) Eligible development business investment tax credit. Effective for tax years beginning on or after January 1, 2001, a business which qualifies as an eligible development business may receive a tax credit of up to 10 percent of the new investment which is directly related to the

construction, expansion or rehabilitation of building space to be used for manufacturing, processing, cold storage, distribution, or office facilities.

An eligible development business must be approved by the Iowa department of economic development prior to March 17, 2004, and meet the qualifications of Iowa Code section 15E.193C. Effective March 17, 2004, the eligible development business program is repealed.

New investment includes the purchase price of land and the cost of improvements made to real property. The tax credit may be claimed by an eligible development business in the tax year in which the construction, expansion or rehabilitation is completed.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following seven years or until used, whichever is the earlier.

If the business is a partnership, S corporation, limited liability company, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

If the eligible development business fails to meet and maintain any one of the requirements to be an eligible business, the business shall be subject to repayment of all or a portion of the amount of tax incentives received. For example, if within five years of project completion the development business sells or leases any space to any retail business, the development business shall proportionally repay the value of the investment credit. The proportion of the investment credit that would be due for repayment by an eligible development business for selling or leasing space to a retail business would be determined by dividing the square footage of building space occupied by the retail business by the square footage of the total building space.

An eligible business which is not a development business and which operates in an enterprise zone cannot claim an investment tax credit if the property is owned, or was previously owned, by an approved development business that has already received an investment tax credit. An eligible business which is not a development business can claim an investment tax credit only on additional new improvements made to real property that was not included in the development business's approved application for the investment tax credit.

This rule is intended to implement Iowa Code section 15E.193C.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.22(15E,422) Venture capital credits.

42.22(1) *Investment tax credit for an equity investment in a qualifying business or community-based seed capital fund.*

a. Equity investments in a qualifying business or community-based seed capital fund before January 1, 2011. See rule 123—2.1(15E) for the discussion of the investment tax credit for an equity investment in a qualifying business or community-based seed capital fund, along with the issuance of tax credit certificates by the Iowa capital investment board, for equity investments made before January 1, 2011. For equity investments made in a qualifying business prior to January 1, 2004, only direct investments made by an individual are eligible for the investment tax credit. Individuals receiving income from a revocable trust's investment in a qualifying business are eligible for the investment tax credit for the portion of the revocable trust's equity investment in a qualifying business.

b. Equity investments in a qualifying business or community-based seed capital fund on or after January 1, 2011, and before July 2, 2015. For equity investments made on or after January 1, 2011, see 261—Chapter 115 for information regarding eligibility for qualifying businesses and community-based seed capital funds, applications for the investment tax credit for equity investments in a qualifying business or community-based seed capital fund, and the issuance of tax credit certificates by the economic development authority.

(1) Certificate issuance. The department of revenue will be notified by the economic development authority when the tax credit certificates are issued.

(2) Amount of the tax credit. The credit is equal to 20 percent of the taxpayer's equity investment in a qualifying business or community-based seed capital fund.

(3) Year in which the tax credit may be claimed. An investment shall be deemed to have been made on the same date as the date of acquisition of the equity interest as determined by the Internal Revenue Code. For investments made prior to January 1, 2014, a taxpayer shall not claim the tax credit prior to the third tax year following the tax year in which the investment is made. For investments made in qualifying businesses on or after January 1, 2014, the credit can be claimed in the year of the investment. However, for investments made in qualifying businesses during the 2014 calendar year, the credit cannot be redeemed prior to January 1, 2016. For example, if an individual taxpayer whose tax year ends on December 31, 2012, makes an equity investment during the 2012 calendar year, the individual taxpayer cannot claim the tax credit until the tax year ending December 31, 2015. However, if the taxpayer dies prior to redeeming the tax credit, the remaining tax credit may be redeemed on the decedent's final income tax return. For fiscal years beginning July 1, 2011, the amount of tax credits authorized cannot exceed $2 million. The tax credit certificate must be included with the taxpayer's return for the tax year in which the credit may be redeemed as stated on the tax credit certificate.

(4) Carried over tax credits. If a tax credit is carried over and issued for the tax year immediately following the year in which the investment was made because the $2 million cap has been reached, the tax credit may be claimed by the taxpayer for the third tax year following the tax year for which the credit is issued. For example, if an individual taxpayer makes an equity investment in December 2012 and the $2 million cap for the fiscal year ending June 30, 2013, had already been reached, the tax credit will be issued for the tax year ending December 31, 2013, and cannot be redeemed until the tax year ending December 31, 2016.

(5) Limitations. Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is the earlier. The tax credit cannot be carried back to a tax year prior to the tax year in which the taxpayer claims the tax credit. The tax credit is not transferable to any other taxpayer.

(6) Pro rata tax credit claims for certain business entities. For equity investments made in a community-based seed capital fund or equity investments made in a qualifying business on or after January 1, 2004, an individual may claim the credit if the investment was made by a partnership, S corporation, limited liability company, or an estate or trust electing to have the income directly taxed to the individual. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

c. Equity investments in a qualifying business on or after July 2, 2015. For equity investments made on or after July 2, 2015, see 261—Chapter 115 for information regarding eligibility for qualifying businesses, applications for the investment tax credit for equity investments in a qualifying business, and the issuance of tax credit certificates by the economic development authority.

(1) Certificate issuance. The department of revenue will be notified by the economic development authority when the tax credit certificates are issued.

(2) Amount of the tax credit. For fiscal years beginning July 1, 2011, the amount of the tax credits authorized cannot exceed $2 million. The credit is equal to 25 percent of the taxpayer's equity investment in a qualifying business. In any one calendar year, the amount of tax credits issued for any one qualifying business shall not exceed $500,000. The maximum amount of tax credit that may be issued per calendar year to a natural person and the person's spouse or dependent shall not exceed $100,000 combined. For purposes of this paragraph, "dependent" has the same meaning as provided by the Internal Revenue Code.

(3) Year in which the tax credit may be claimed. A taxpayer shall not claim a tax credit prior to September 1, 2016. The tax credit certificate must be included with the taxpayer's return for the tax year in which the credit may be redeemed as stated on the tax credit certificate. For purposes of this paragraph, an investment shall be deemed to have been made on the same date as the date of acquisition of the equity interest as determined by the Internal Revenue Code.

(4) Pro rata tax credit claims for certain business entities. An individual may claim the credit if the investment was made by a partnership, S corporation, limited liability company, or an estate or trust electing to have the income directly taxed to the individual. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, S corporation,

limited liability company, or estate or trust. Any credits claimed by an individual are subject to the limitations provided in 42.22(1)*"c"*(2) above.

(5) Refundability. For a tax credit claimed against the taxes imposed in Iowa Code chapter 422, division II, any tax credit in excess of the tax liability is refundable. In lieu of claiming a refund, the taxpayer may elect to have the overpayment shown on the taxpayer's final completed return credited to the tax liability for the following tax year.

(6) Transfers and carryback of tax credits prohibited. The tax credit cannot be carried back to a tax year prior to the tax year in which the taxpayer claims the tax credit. The tax credit is not transferable to any other taxpayer.

42.22(2) *Investment tax credit for an equity investment in a venture capital fund.* See rule 123—3.1(15E) for the discussion of the investment tax credit for an equity investment in a venture capital fund, along with the issuance of tax credit certificates by the Iowa capital investment board. This credit is repealed for investments in venture capital funds made after July 1, 2010.

The department of revenue will be notified by the Iowa capital investment board when the tax credit certificates are issued. The tax credit certificate must be attached to the taxpayer's return for the tax year in which the credit may be redeemed as stated on the tax credit certificate.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is the earlier.

For equity investments made in a venture capital fund, an individual may claim the credit if the investment was made by a partnership, S corporation, limited liability company, or an estate or trust electing to have the income directly taxed to the individual. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

42.22(3) *Contingent tax credit for investments in Iowa fund of funds.* See rule 123—4.1(15E) for the discussion of the contingent tax credit available for investments made in the Iowa fund of funds organized by the Iowa capital investment corporation. Tax credit certificates related to the contingent tax credits will be issued by the Iowa capital investment board.

The department of revenue will be notified by the Iowa capital investment board when these tax credit certificates are issued and, if applicable, when they are redeemed. If the tax credit certificate is redeemed, the certificate must be attached to the taxpayer's return for the tax year in which the credit may be redeemed as stated on the tax credit certificate.

If the tax credit certificate is redeemed, any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following seven years or until used, whichever is the earlier.

If the tax credit certificate is redeemed, an individual may claim the credit if the investment was made by a partnership, S corporation, limited liability company, or an estate or trust electing to have the income directly taxed to the individual. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

42.22(4) *Innovation fund investment tax credit.* See 261—Chapter 116 for information regarding eligibility for an innovation fund, applications for the investment tax credit for investments in an innovation fund, and the issuance of tax credit certificates by the economic development authority.

The department of revenue will be notified by the economic development authority when the tax credit certificates are issued. The credit is equal to 20 percent of the taxpayer's equity investment in the form of cash in an innovation fund for tax years beginning and investments made on or after January 1, 2011, and before January 1, 2013. For tax years beginning and investments made on or after January 1, 2013, the taxpayer may claim a tax credit equal to 25 percent of the taxpayer's equity investment in the form of cash in an innovation fund. An investment shall be deemed to have been made on the same date as the date of acquisition of the equity interest as determined by the Internal Revenue Code. A taxpayer shall claim the tax credit for the tax year in which the investment is made. For fiscal years beginning July 1, 2011, the amount of tax credits authorized cannot exceed $8 million. No tax credit certificates will be issued prior to September 1, 2014. The tax credit certificate must be attached to the taxpayer's return for the tax year in which the investment was made as stated on the tax credit certificate.

If a tax credit is carried over and issued for the tax year immediately following the year in which the investment was made because the $8 million cap has been reached, the tax credit may be claimed by the taxpayer for the tax year following the tax year for which the credit is issued. For example, if an individual taxpayer makes an equity investment in December 2013 and the $8 million cap for the fiscal year ending June 30, 2014, had already been reached, the tax credit will be issued for the tax year ending December 31, 2014, and can be redeemed for the tax year ending December 31, 2014.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until depleted, whichever is the earlier. The tax credit cannot be carried back to a tax year prior to the tax year in which the taxpayer claims the tax credit.

The innovation fund tax credit certificate may be transferred once to any person or entity.

Within 90 days of transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the department, along with a statement which contains the transferee's name, address and tax identification number and the amount of the tax credit being transferred. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee, the department will issue a replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company, S corporation, or estate or trust claiming the credit for individual or corporation income tax, the transferee shall provide a list of the partners, members, shareholders or beneficiaries and information on how the innovation fund tax credit should be divided among the partners, members, shareholders or beneficiaries. The transferee shall also provide the tax identification numbers and addresses of the partners, members, shareholders or beneficiaries. The replacement tax credit certificate must contain the same information as that on the original tax credit certificate and must have the same effective taxable year and the same expiration date as the original tax credit certificate. The replacement tax credit certificate may reflect a different tax type than the original tax credit certificate.

The transferee may use the amount of the tax credit for any tax year for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit certificate shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit certificate shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

For equity investments made in an innovation fund, an individual may claim the credit if the investment was made by a partnership, S corporation, limited liability company, estate or trust electing to have the income directly taxed to the individual. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

This rule is intended to implement Iowa Code sections 15E.51, 15E.52, 15E.66, 422.11F, and 422.11G and section 15E.43 as amended by 2015 Iowa Acts, chapter 138.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10; **ARC 9966B**, IAB 1/11/12, effective 2/15/12; **ARC 1102C**, IAB 10/16/13, effective 11/20/13; **ARC 1665C**, IAB 10/15/14, effective 11/19/14; **ARC 2632C**, IAB 7/20/16, effective 8/24/16]

701—42.23(15) New capital investment program tax credits. Effective for tax periods beginning on or after January 1, 2003, a business which qualifies under the new capital investment program is eligible to receive tax credits. An eligible business under the new capital investment program must be approved by the Iowa department of economic development and meet the qualifications of 2003 Iowa Acts, chapter 125, section 4. The new capital investment program was repealed on July 1, 2005, and has been replaced with the high quality job creation program. See rule 701—42.29(15) for information on the tax credits available under the high quality job creation program. Any tax credits earned by businesses approved under the new capital investment program prior to July 1, 2005, remain valid and can be claimed on tax returns filed after July 1, 2005.

42.23(1) *Research activities credit.* A business approved under the new capital investment program is eligible for an additional research activities credit as described in 701—subrule 52.7(5). This credit for increasing research activities is in lieu of the research activities credit described in subrule 42.11(3).

42.23(2) *Investment tax credit.*

a. General rule. An eligible business can claim an investment tax credit equal to a percentage of the new investment directly related to new jobs created by the location or expansion of an eligible business. The percentage is equal to the amount provided in paragraph *"b."* New investment directly related to new jobs created by the location or expansion of an eligible business includes the following:

(1) The cost of machinery and equipment, as defined in Iowa Code section 427A.1(1), paragraphs *"e"* and *"j,"* purchased for use in the operation of the eligible business. The purchase price shall be depreciated in accordance with generally accepted accounting principles.

(2) The purchase price of real property and any buildings and structures located on the real property.

(3) The cost of improvements made to real property which is used in the operation of the eligible business.

For eligible businesses approved by the Iowa department of economic development on or after March 17, 2004, certain lease payments made by eligible businesses to a third-party developer will be considered to be new investment for purposes of computing the investment tax credit. The eligible business shall enter into a lease agreement with the third-party developer for a minimum of five years. The investment tax credit is based on the annual base rent paid to a third-party developer by the eligible business for a period not to exceed ten years. The total costs of the annual base rent payments for the ten-year period cannot exceed the cost of the land and the third-party developer's cost to build or renovate the building used by the eligible business. The annual base rent is defined as the total lease payment less taxes, insurance and operating and maintenance expenses.

Any credit in excess of the tax liability for the tax period may be carried forward seven years or until used, whichever is the earlier.

If the business is a partnership, S corporation, limited liability company, cooperative organized under Iowa Code chapter 501 and filing as a partnership for federal tax purposes, or estate or trust electing to have the income taxed directly to an individual, an individual may claim the credit. The amount of the credit claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, S corporation, limited liability company, cooperative organized under Iowa Code chapter 501 and filing as a partnership for federal tax purposes, or estate or trust.

b. Tax credit percentage. The amount of tax credit claimed shall be based on the number of high quality jobs created as determined by the Iowa department of economic development:

(1) If no high quality jobs are created but economic activity within Iowa is advanced, the eligible business may claim a tax credit of up to 1 percent of the new investment.

(2) If 1 to 5 high quality jobs are created, the eligible business may claim a tax credit of up to 2 percent of the new investment.

(3) If 6 to 10 high quality jobs are created, the eligible business may claim a tax credit of up to 3 percent of the new investment.

(4) If 11 to 15 high quality jobs are created, the eligible business may claim a tax credit of up to 4 percent of the new investment.

(5) If 16 or more high quality jobs are created, the eligible business may claim a tax credit of up to 5 percent of the new investment.

c. Investment tax credit—value-added agricultural products or biotechnology-related processes. An eligible business whose project primarily involves the production of value-added agricultural products or uses biotechnology-related processes may elect to receive a refund for all or a portion of an unused investment tax credit. An eligible business includes a cooperative described in Section 521 of the Internal Revenue Code whose project primarily involves the production of ethanol.

Eligible businesses that elect to receive a refund shall apply to the Iowa department of economic development for tax credit certificates between May 1 and May 15 of each fiscal year through the fiscal year ending June 30, 2009. The election to receive a refund of all or a portion of an unused investment tax credit is no longer available beginning with the fiscal year ending June 30, 2010. Only those businesses that have completed projects before the May 1 filing date may apply for a tax credit certificate. The Iowa department of economic development shall not issue tax credit certificates for more than $4 million during a fiscal year to eligible businesses for this program and eligible businesses described in subrule

42.14(2). If applications are received for more than $4 million, the applicants shall receive certificates for a prorated amount.

The economic development authority shall issue tax credit certificates within a reasonable period of time. Tax credit certificates are valid for the tax year following project completion. The tax credit certificate must be included with the tax return for the tax year during which the tax credit is claimed. The tax credit certificate shall not be transferred, except for a cooperative described in Section 521 of the Internal Revenue Code whose project primarily involves the production of ethanol, as provided in subrule 42.14(2). For value-added agricultural projects involving ethanol, the cooperative must submit a list of its members and the share of each member's interest in the cooperative. The economic development authority shall issue a tax credit certificate to each member on the list.

d. Repayment of benefits. If an eligible business fails to maintain the requirements of the new capital investment program, the taxpayer may be required to repay all or a portion of the tax incentives taken on Iowa returns. Irrespective of the fact that the statute of limitations to assess the taxpayer for repayment of the tax credits may have expired, the department may proceed to collect the tax incentives forfeited by failure to maintain the requirements of the new capital investment program. This repayment is required because it is a recovery of an incentive, rather than an adjustment to the taxpayer's tax liability. Details on the calculation of the repayment can be found in 261—subrule 187.5(4) of the administrative rules of the economic development authority. If the business is a partnership, limited liability company, S corporation, estate or trust where the income of the taxpayer is taxed to the individual owner(s) of the business, the department may proceed to collect the tax incentives against the partners, members, shareholders or beneficiaries to whom the tax incentives were passed through. See Decision of the Administrative Law Judge in *Damien & Colette Trebilcock, et al.,* Docket No. 11DORF 042-044, June 11, 2012.

An eligible business in the new capital investment program may also be required to repay all or a portion of the tax incentives received on Iowa returns if the eligible business experiences a layoff of employees in Iowa or closes any of its facilities in Iowa.

If, within five years of purchase, the eligible business sells, disposes of, razes, or otherwise renders unusable all or a part of the land, buildings, or other existing structures for which a tax credit was claimed under this subrule, the income tax liability of the eligible business shall be increased by one of the following amounts:

(1) One hundred percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within one full year after being placed in service.

(2) Eighty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within two full years after being placed in service.

(3) Sixty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within three full years after being placed in service.

(4) Forty percent of the tax credit claimed if the property ceases to be eligible for the tax credit within four full years after being placed in service.

(5) Twenty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within five full years after being placed in service.

This rule is intended to implement Iowa Code section 15.333 as amended by 2010 Iowa Acts, Senate File 2380, and sections 15.335 and 15.381 to 15.387.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10; **ARC 1744C**, IAB 11/26/14, effective 12/31/14]

701—42.24(15E,422) Endow Iowa tax credit. Effective for tax years beginning on or after January 1, 2003, a taxpayer who makes an endowment gift to an endow Iowa qualified community foundation may qualify for an endow Iowa tax credit, subject to the availability of the credit. For tax years beginning on or after January 1, 2003, but before January 1, 2010, the credit is equal to 20 percent of a taxpayer's endowment gift to an endow Iowa qualified community foundation approved by the Iowa department of economic development. For tax years beginning on or after January 1, 2010, the credit is equal to 25 percent of a taxpayer's endowment gift to an endow Iowa qualified community foundation approved by

the Iowa department of economic development. For tax years beginning on or after January 1, 2010, a taxpayer cannot claim a deduction for charitable contributions under Section 170 of the Internal Revenue Code for the amount of the contribution for which the tax credit is claimed for Iowa tax purposes. The administrative rules for the endow Iowa tax credit for the Iowa department of economic development may be found under 261—Chapter 47.

The total amount of endow Iowa tax credits available is $2 million in the aggregate for the 2003 and 2004 calendar years. The total amount of endow Iowa tax credits is $2 million annually for the 2005-2007 calendar years, and $200,000 of these tax credits on an annual basis is reserved for endowment gifts of $30,000 or less. The maximum amount of tax credit granted to a single taxpayer shall not exceed $100,000 for the 2003-2007 calendar years. The total amount of endow Iowa tax credits annually for the 2008 and 2009 calendar years is $2 million plus a percentage of the tax imposed on the adjusted gross receipts from gambling games in accordance with Iowa Code section 99F.11(3). The total amount of endow Iowa tax credits annually for 2010 is $2.7 million plus a percentage of the tax imposed on the adjusted gross receipts from gambling games in accordance with Iowa Code section 99F.11(3). The total amount of endow Iowa tax credits annually for 2011 is $3.5 million plus a percentage of the tax imposed on the adjusted gross receipts from gambling games in accordance with Iowa Code section 99F.11(3). The maximum amount of tax credit granted to a single taxpayer shall not exceed 5 percent of the total endow Iowa tax credit amount authorized for 2008 and subsequent years. For the 2012 calendar year and subsequent calendar years, the total amount of endow Iowa tax credits is $6 million; the maximum amount of tax credit authorized to a single taxpayer is $300,000 ($6 million multiplied by 5 percent). The endow Iowa tax credit cannot be transferred to any other taxpayer.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is the earlier.

If a taxpayer is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement Iowa Code section 15E.305 as amended by 2013 Iowa Acts, House File 620, and section 422.11H.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10; **ARC 9876B**, IAB 11/30/11, effective 1/4/12; **ARC 0398C**, IAB 10/17/12, effective 11/21/12; **ARC 1138C**, IAB 10/30/13, effective 12/4/13]

701—42.25(422) Soy-based cutting tool oil tax credit. Effective for tax periods ending after June 30, 2005, and beginning before January 1, 2007, a manufacturer may claim a soy-based cutting tool oil tax credit. A manufacturer, as defined in Iowa Code section 428.20, may claim the credit equal to the costs incurred during the tax year for the purchase and replacement costs relating to the transition from using nonsoy-based cutting tool oil to using soy-based cutting tool oil.

All of the following conditions must be met to qualify for the tax credit:

1. The costs must be incurred after June 30, 2005, and before January 1, 2007.
2. The costs must be incurred in the first 12 months of the transition from using nonsoy-based cutting tool oil to using soy-based cutting tool oil.
3. The soy-based cutting tool oil must contain at least 51 percent soy-based products.
4. The costs of the purchase and replacement must not exceed $2 per gallon of soy-based cutting tool oil used in the transition.
5. The number of gallons used in the transition cannot exceed 2,000 gallons.
6. The manufacturer shall not deduct for Iowa income tax purposes the costs incurred in the transition to using soy-based cutting tool oil which are deductible for federal tax purposes.

Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

If a taxpayer is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to an individual, an individual may claim the credit. The amount

claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement Iowa Code section 422.11I.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.26(15I,422) Wage-benefits tax credit. Effective for tax years ending on or after June 9, 2006, a wage-benefits tax credit equal to a percentage of the annual wages and benefits paid for a qualified new job created by the location or expansion of the business in Iowa is available for qualified businesses.

42.26(1) *Definitions.* The following definitions are applicable to this rule:

"Average county wage" means the annualized average hourly wage calculated by the Iowa department of economic development using the most current four quarters of wage and employment information as provided in the Quarterly Covered Wage and Employment Data report provided by the department of workforce development. Agricultural/mining and governmental employment categories are deleted in compiling the wage information.

"Benefits" means all of the following:

1. Medical and dental insurance plans.
2. Pension and profit-sharing plans.
3. Child care services.
4. Life insurance coverage.
5. Vision insurance plan.
6. Disability coverage.

"Department" means the Iowa department of revenue.

"Full-time" means the equivalent of employment of one person:

1. For 8 hours per day for a five-day, 40-hour workweek for 52 weeks per year, including paid holidays, vacations, and other paid leave, or
2. The number of hours or days per week, including paid holidays, vacations, and other paid leave, currently established by schedule, custom or otherwise, as constituting a week of full-time work for the kind of service an individual performs for an employing unit.

"Grow Iowa values fund" means the grow Iowa values fund created in Iowa Code Supplement section 15G.108.

"Nonqualified new job" means any one of the following:

1. A job previously filled by the same employee in Iowa.
2. A job that was relocated from another location in Iowa.
3. A job that is created as a result of a consolidation, merger, or restructuring of a business entity if the job does not represent a new job in Iowa.

"Qualified new job" or *"job creation"* means a job that meets all of the following criteria:

1. Is a new full-time job that has not existed in the business in Iowa within the previous 12 months.
2. Is filled by a new employee for at least 12 months.
3. Is filled by a resident of the state of Iowa.
4. Is not created as a result of a change in ownership.
5. Was created on or after June 9, 2005.

"Retail business" means a business which sells its product directly to a consumer.

"Retained qualified new job" or *"job retention"* means the continued employment, after the first 12 months of employment, of the same employee in a qualified new job for another 12 months.

"Service business" means a business which is not engaged in the sale of tangible personal property, and which provides services to a local consumer market and does not have a significant proportion of its sales coming from outside Iowa.

42.26(2) *Calculation of credit.* A business which is not a retail or service business may claim the wage-benefits tax credit which is determined as follows:

a. If the annual wages and benefits for the qualified new job equal less than 130 percent of the average county wage, the credit is 0 percent of the annual wage and benefits paid.

b. If the annual wages and benefits for the qualified new job equal at least 130 percent but less than 160 percent of the average county wage, the credit is 5 percent of the annual wage and benefits paid for each qualified new job.

c. If the annual wages and benefits for the qualified new job equal at least 160 percent of the average county wage, the credit is 10 percent of the annual wage and benefits paid for each qualified new job.

If the business is a partnership, S corporation, limited liability company, or estate or trust electing to have the income taxed directly to the individual, an individual may claim the tax credit. The amount claimed by the individual shall be based upon the pro rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

42.26(3) *Application for the tax credit; tax credit certificate; amount of tax credit available.*

a. In order to claim the wage-benefits tax credit, the business must submit an application to the department along with information on the qualified new job or retained qualified new job. The application cannot be submitted until the end of the twelfth month after the qualified job was filled. For example, if the new job was created on June 9, 2005, the application cannot be submitted until June 9, 2006. The following information must be submitted in the application:

(1) Name, address and federal identification number of the business.

(2) A description of the activities of the business. If applicable, the proportion of the sales of the business which come from outside Iowa shall be included.

(3) The amount of wages and benefits paid to each employee for each new job for the previous 12 months.

(4) A computation of the amount of credit being requested.

(5) The address and state of residence of each new employee.

(6) The date that the qualified new job was filled.

(7) An indication of whether the job is a qualified new job or a retained qualified new job for which an application was filed for a previous year.

(8) The type of tax for which the credit will be applied.

(9) If the business is a partnership, S corporation, limited liability company, or estate or trust, a schedule of the partners, shareholders, members or beneficiaries. This schedule shall include the names, addresses and federal identification numbers of the partners, shareholders, members or beneficiaries, along with their percentage of the pro rata share of earnings of the partnership, S corporation, limited liability company, or estate or trust.

b. Upon receipt of the application, the department has 45 days either to approve or deny the application. If the department does not act on the application within 45 days, the application is deemed approved. If the department denies the application, the business may appeal the decision to the Iowa economic development board within 30 days of the notice of denial.

c. If the application is approved, or if the Iowa economic development board approves the application that was previously denied by the department, a tax credit certificate will be issued by the department to the business, subject to the availability of the amount of credits that may be issued. The tax credit certificate shall contain the name, address and tax identification number of the business (or individual, estate or trust, if applicable), the date of the qualified new job(s), the wage and benefits paid for each job(s) for the 12-month period, the amount of the credit, the tax period for which the credit may be applied, and the type of tax for which the credit will be applied.

d. The tax credit certificates that are issued in a fiscal year cannot exceed $10 million for the fiscal year ending June 30, 2007, and shall not exceed $4 million for the fiscal years ending June 30, 2008, through June 30, 2011. The tax credit certificates are issued on a first-come, first-served basis. Therefore, if tax credit certificates have already been issued for the $10 million limit for the fiscal year ending June 30, 2007, any applications for tax credit certificates received after the $10 million limit has been reached will be denied. Similarly, if tax credit certificates have already been issued for the $4 million limit for the fiscal years ending June 30, 2008, through June 30, 2011, any applications for tax credit certificates

received after the $4 million limit has been reached will be denied. If a business failed to receive all or a part of the tax credit due to the $10 million or $4 million limitation, the business may reapply for the tax credit for the retained new job for a subsequent tax period.

e. A business which qualifies for the tax credit for the fiscal year ending June 30, 2007, is eligible to receive the tax credit certificate for each of the fiscal years ending June 30, 2008, through June 30, 2011, subject to the $4 million limit for tax credits for the fiscal years ending June 30, 2008, through June 30, 2011, if the business retains the qualified new job during each of the fiscal years ending June 30, 2008, through June 30, 2011. The business must reapply by June 30 of each fiscal year for the tax credit, and the percentage of the wages and benefits allowed for the credit set forth in subrule 42.26(2) for the first year is applicable for each subsequent period. Preference will be given in issuing tax credit certificates for those businesses that retain qualified new jobs, and preference will be given in the order in which applications were filed for the fiscal year ending June 30, 2007. Therefore, those businesses which received the first $4 million of tax credits for the year ending June 30, 2007, in which the qualified jobs were created will automatically receive a tax credit for the fiscal years ending June 30, 2008, through June 30, 2011, as long as the qualified jobs are retained and an application is completed.

f. For the fiscal years ending June 30, 2008, through June 30, 2011, if credits become available because the jobs were not retained by businesses which received the first $4 million of credits for the year ending June 30, 2007, an application which was originally denied will be considered in the order in which the application was received for the fiscal year ending June 30, 2007.

EXAMPLE: Wage-benefits tax credits of $4 million are issued for the fiscal year ending June 30, 2007, relating to applications filed between July 1, 2006, and March 31, 2007. For the next fiscal year ending June 30, 2008, the same businesses that received the $4 million in wage-benefits tax credits filed applications totaling $3 million for the retained jobs for which the application for the prior year was filed on or before March 31, 2007. The first $3 million of the available $4 million will be allowed to these same businesses. The remaining $1 million that is still available for the fiscal year ending June 30, 2008, will be allowed for those retained jobs for which applications for the prior year were filed starting on April 1, 2007, until the remaining $1 million in tax credits is issued.

g. A business may apply in writing to the Iowa economic development board for a waiver of the average wage and benefit requirement. If a waiver is granted, the business must provide the department with the waiver and it must be attached to the application.

h. A business may receive other federal, state, and local incentives and tax credits in addition to the wage-benefits tax credit. However, a business that receives a wage-benefits tax credit cannot receive tax incentives under the high quality job creation program set forth in Iowa Code chapter 15 or moneys from the grow Iowa values fund.

42.26(4) *Examples.* The following noninclusive examples illustrate how this rule applies:

EXAMPLE 1: Business A operates a grocery store and hires five new employees, each of whom will earn wages and benefits in excess of 130 percent of the average county wage. Business A would not qualify for the wage-benefits tax credit because Business A is a retail business.

EXAMPLE 2: Business B operates an accounting firm and hires two new accountants, each of whom will earn wages and benefits in excess of 160 percent of the average county wage. The accounting firm provides services to clients wholly within Iowa. Business B would not qualify for the wage-benefits tax credit because it is a service business. The majority of its sales are generated from within the state of Iowa and thus Business B, because it is a service business, is not eligible for the credit.

EXAMPLE 3: Business C operates a software development business and hires two new programmers, each of whom will earn wages and benefits in excess of 160 percent of the average county wage. Over 50 percent of the customers of Business C are located outside Iowa. Business C would qualify for the wage-benefits tax credit because a majority of its sales are coming from outside the state, even though Business C is engaged in the performance of services.

EXAMPLE 4: Business D is a manufacturer that hires a new employee in Clayton County, Iowa, on July 8, 2005. The average county wage for Clayton County for the third quarter of 2005 is $11.86 per hour. If the average county wage per hour for Clayton County is $11.95 for the fourth quarter of 2005, $12.05 for the first quarter of 2006, and $12.14 for the second quarter of 2006, the annualized

average county wage for this 12-month period is $12.00 per hour. This wage equates to an average annual wage of $24,960 ($12.00 × 40 hours × 52 weeks). In order for Business D to qualify for the 5 percent wage-benefits tax credit, the new employee must receive wages and benefits totaling $32,448 (130 percent of $24,960) for the 12-month period from July 8, 2005, through July 7, 2006. In order for Business D to qualify for the 10 percent wage-benefits tax credit, the new employee must receive wages and benefits totaling $39,936 (160 percent of $24,960) for the 12-month period from July 8, 2005, through July 7, 2006.

EXAMPLE 5: Business E is a manufacturer that hires three new employees in Grundy County, Iowa, on July 1, 2005. If the average county wage for the 12-month period from July 1, 2005, through June 30, 2006, is $13.75 per hour in Grundy County, this wage equates to an average county wage of $28,600. The wages and benefits for each of these three new employees is $40,000 for the period from July 1, 2005, through June 30, 2006, which is 140 percent of the average county wage. Business E is entitled to a wage-benefits tax credit of $2,000 for each employee ($40,000 × 5 percent), for a total wage-benefits tax credit of $6,000. If Business E files on a calendar-year basis, the $6,000 wage-benefits tax credit can be claimed on the tax return for the period ending December 31, 2006.

EXAMPLE 6: Business F is a manufacturer that hires ten new employees on July 1, 2005, and qualifies for the wage-benefits tax credit because the wages and benefits paid exceed 130 percent of the average county wage. Business F receives a wage-benefits tax credit in July 2006 for these ten employees, which can be used on the tax return for the period ending December 31, 2006. On August 31, 2006, two of the employees leave the business and are replaced by two new employees. Business F is entitled to a wage-benefits tax credit for only eight employees in July 2007 because only eight employees continued employment for the subsequent 12 months in a job which meets the definition of a retained qualified new job. Business F cannot request a wage-benefits tax credit for the two employees hired on August 31, 2006. Business F cannot request the wage-benefits tax credit because these two full-time jobs existed in the business within the previous 12 months in Iowa, and these jobs do not meet the definition of a qualified new job or retained qualified new job.

EXAMPLE 7: Business G is a manufacturer that hires ten new employees on July 1, 2005, and qualifies for the wage-benefits tax credit because the wages and benefits paid exceed 130 percent of the average county wage. Business G receives a wage-benefits tax credit in July 2006 for these ten employees equal to 5 percent of the wages and benefits paid. On October 1, 2006, Business G hires an additional five employees, each of whom receives wages and benefits in excess of 130 percent of the average county wage. Business G can apply for the wage-benefits tax credit on October 1, 2007, for these five employees, since these employees have now been employed for 12 months. However, the credit may not be allowed if more than $4 million of retained job tax credits have been issued for the fiscal year ending June 30, 2008.

EXAMPLE 8: Assume the same facts as Example 6, except that the $10 million limit of tax credits has already been met for the fiscal year ending June 30, 2007, and Business F hired five new employees on August 31, 2006. Business F can apply for the wage-benefits tax credit for the three employees on August 31, 2007, a number which is above the ten full-time jobs originally created, but Business F may not receive the tax credit if more than $4 million of retained job tax credits have been issued for the fiscal year ending June 30, 2008.

EXAMPLE 9: Assume the same facts as Example 7, except that the ten employees hired on July 1, 2005, by Business G received wages and benefits equal to 155 percent of the average county wage, and the five employees hired on October 1, 2006, by Business G received wages equal to 161 percent of the average county wage. Business G can apply for the tax credit on October 1, 2007, equal to 10 percent of the wages and benefits paid for the employees hired on October 1, 2006. On July 1, 2007, Business G can reapply for the tax credit equal to 5 percent of the wages and benefits paid only for the ten employees originally hired on July 1, 2005, even if the wages and benefits for these ten employees exceed 160 percent of the average county wage for the period from July 1, 2006, through June 30, 2007.

42.26(5) *Repeal of the wage-benefits tax credit.* The wage-benefits tax credit is repealed effective July 1, 2008. However, the wage-benefits tax credit is still available through the fiscal year ending June

30, 2011, as provided in subrule 42.26(3), paragraphs *"d," "e,"* and *"f."* A business is not entitled to a wage-benefits tax credit for a qualified new job created on or after July 1, 2008.

This rule is intended to implement Iowa Code chapter 15I and section 422.11L.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.27(422,476B) Wind energy production tax credit. Effective for tax years beginning on or after July 1, 2006, an owner of a qualified wind energy production facility that has been approved by the Iowa utilities board may claim a wind energy production tax credit for qualified electricity sold by the owner or used for on-site consumption against a taxpayer's Iowa individual income tax liability. The administrative rules for the certification of eligibility for the wind energy production tax credit for the Iowa utilities board may be found in rule 199—15.18(476B).

42.27(1) *Application and review process for the wind energy production tax credit.* An owner of a wind energy production facility must be approved by the Iowa utilities board in order to qualify for the wind energy production tax credit. The facility must be an electrical production facility that produces electricity from wind, that is located in Iowa, and that is placed in service on or after July 1, 2005, but before July 1, 2012. For applications filed on or after March 1, 2008, a facility must consist of one or more wind turbines which have a combined nameplate generating capacity of at least 2 megawatts and no more than 30 megawatts. For applications filed on or after July 1, 2009, by a private college or university, community college, institution under the control of the state board of regents, public or accredited nonpublic elementary and secondary school, or public hospital as defined in Iowa Code section 249J.3, the facility must have a combined nameplate generating capacity of no less than ¾ of a megawatt.

The maximum amount of nameplate generating capacity for all qualified wind energy production facilities cannot exceed 50 megawatts. An owner shall not own more than two qualified facilities. A facility that is not operational within 18 months after issuance of the approval from the Iowa utilities board will no longer be considered a qualified facility. However, a facility that is not operational within 18 months due to the unavailability of necessary equipment shall be granted an additional 12 months to become operational.

An owner of the qualified facility must apply to the Iowa utilities board for the wind energy production tax credit. The application for the tax credit must be filed no later than 30 days after the close of the tax year for which the credit is applied. The information to be included in the application is set forth in 199—subrule 15.20(1).

42.27(2) *Computation of the credit.* The wind energy production credit equals one cent multiplied by the number of kilowatt-hours of qualified electricity sold or used for on-site consumption by the owner during the tax year. For the first tax year in which the credit is applied, the kilowatt-hours of qualified electricity sold may exceed 12 months.

EXAMPLE: A qualified facility was placed in service on April 1, 2006, and the taxpayer files on a calendar-year basis. The first year for which the credit can be claimed is the period ending December 31, 2007, since that is the first tax year that began on or after July 1, 2006. The credit for the 2007 tax year can include electricity sold between April 1, 2006, and December 31, 2007.

The credit is not allowed for any kilowatt-hours of electricity sold to a related person. The definition of "related person" uses the same criteria set forth in Section 45(e)(4) of the Internal Revenue Code relating to the federal renewable electricity production credit. Persons shall be treated as related to each other if such persons are treated as a single employer under Treasury Regulation § 1.52-1. In the case of a corporation that is a member of an affiliated group of corporations filing a federal consolidated return, such corporation shall be treated as selling electricity to an unrelated person if such electricity is sold to the person by another member of the affiliated group.

The utilities board will notify the department of the number of kilowatt-hours of electricity sold by the qualified facility or generated and used on site by the qualified facility during the tax year. The department will calculate the credit and issue a tax credit certificate to the owner. The tax credit certificate will include the taxpayer's name, address and federal identification number, the tax type for which the credit will be claimed, the amount of the credit and the tax year for which the credit may be claimed. In addition, the tax credit certificate will include a place for the name and tax identification number of a transferee

and the amount of the tax credit certificate, as provided in subrule 42.27(3). If the department refuses to issue the tax credit certificate, the taxpayer shall be notified in writing and the taxpayer will have 60 days from the date of denial to file a protest in accordance with rule 701—7.8(17A). The department will not issue a tax credit certificate if the facility is not operational within 18 months after approval was given by the utilities board, unless a 12-month extension is granted by the utilities board as provided in subrule 42.27(1).

If the taxpayer is a partnership, limited liability company, S corporation, or estate or trust requesting a credit for individual or corporation income tax, the tax credit certificate will be issued to the partners, members, shareholders or beneficiaries based on the partner's, member's, shareholder's or beneficiary's pro rata share of earnings of the partnership, limited liability company, S corporation, or estate or trust, except when the taxpayer is eligible to receive renewable electricity production tax credits authorized under Section 45 of the Internal Revenue Code. In cases where the taxpayer is eligible to receive renewable electricity production tax credits under Section 45 of the Internal Revenue Code, the partnership, limited liability company or S corporation may designate the amount of the tax credit to be allocated to each partner, member or shareholder. In addition, if a taxpayer is a partnership, limited liability company, S corporation, or estate or trust that is eligible to receive renewable electricity production tax credits under Section 45 of the Internal Revenue Code, the taxpayer may distribute the tax credit to an equity holder or beneficiary as a liquidating distribution, or portion thereof, of an equity holder's interest in the partnership, limited liability company or S corporation, or the beneficiary's interest in the estate or trust.

The credit can be allowed for a ten-year period beginning on the date the qualified facility was originally placed in service. For example, if a facility was placed in service on April 1, 2006, the credit can be claimed for kilowatt-hours of electricity sold between April 1, 2006, and March 31, 2016.

To claim the tax credit, the taxpayer must include the tax credit certificate with the tax return for the tax year set forth on the certificate. Any tax credit in excess of the tax liability may be carried forward for seven years or until it is used, whichever is the earlier.

42.27(3) *Transfer of the wind energy production tax credit certificate.* The wind energy production tax credit certificate may be transferred to any person or entity.

Within 30 days of transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the department, along with a statement which contains the transferee's name, address and tax identification number and the amount of the tax credit being transferred. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee, the department will issue a replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company, S corporation, or estate or trust claiming the credit for individual or corporation income tax, the transferee shall provide a list of the partners, members, shareholders or beneficiaries and information on how the wind energy production tax credit should be divided among the partners, members, shareholders or beneficiaries. The transferee shall also provide the tax identification numbers and addresses of the partners, members, shareholders or beneficiaries. The replacement tax credit certificate must contain the same information as that on the original tax credit certificate and must have the same effective taxable year and the same expiration date as the original tax credit certificate. The replacement tax credit certificate may reflect a different tax type than the original tax credit certificate.

The transferee may use the amount of the tax credit for any tax year for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit certificate shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit certificate shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

This rule is intended to implement Iowa Code section 422.11J and Iowa Code chapter 476B as amended by 2011 Iowa Acts, House File 672.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9876B**, IAB 11/30/11, effective 1/4/12; **ARC 0251C**, IAB 8/8/12, effective 9/12/12; **ARC 1744C**, IAB 11/26/14, effective 12/31/14]

701—42.28(422,476C) Renewable energy tax credit. Effective for tax years beginning on or after July 1, 2006, a purchaser or producer of renewable energy whose facility has been approved by the Iowa utilities board may claim a renewable energy tax credit for qualified renewable energy against a taxpayer's Iowa individual income tax liability.

42.28(1) *Eligible facility application process.*

a. Eligible facility application process, generally. A producer or purchaser of a renewable energy facility must be approved as an eligible renewable energy facility by the Iowa utilities board in order to qualify for the renewable energy tax credit. The eligible renewable energy facility can be a wind energy conversion facility, biogas recovery facility, biomass conversion facility, methane gas recovery facility, solar energy conversion facility or refuse conversion facility. The facility must be located in Iowa and placed in service on or after July 1, 2005, and before January 1, 2018. The administrative rules for the certification of eligibility for the renewable energy tax credit for the Iowa utilities board may be found in rule 199—15.19(476C).

b. Limitations on maximum energy production and nameplate generating capacity. The maximum amount of nameplate generating capacity of all wind energy conversion facilities cannot exceed 363 megawatts. For tax years beginning prior to January 1, 2015, the maximum amount of energy production capacity for biogas recovery facilities, biomass conversion facilities, methane gas recovery facilities, solar energy conversion facilities and refuse conversion facilities cannot exceed a combined output of 53 megawatts of nameplate generating capacity and 167 billion British thermal units of heat for a commercial purpose. For tax years beginning on or after January 1, 2015, the maximum amount of energy production for biogas recovery facilities, biomass conversion facilities, methane gas recovery facilities, solar energy conversion facilities and refuse conversion facilities cannot exceed a combined output of 63 megawatts of nameplate generating capacity and, annually, 167 billion British thermal units of heat for a commercial purpose. A facility that is not operational within 30 months after issuance of approval from the utilities board will no longer be considered a qualified facility. However, if the facility is a wind energy conversion property and is not operational within 18 months due to the unavailability of necessary equipment, the facility may apply for a 12-month extension of the 30-month limit. Extensions can be renewed for succeeding 12-month periods if the facility applies for the extension prior to expiration of the current extension period. A producer of renewable energy, who is the person who owns the renewable energy facility, cannot own more than two eligible renewable energy facilities. A person that has an equity interest equal to or greater than 51 percent in an eligible renewable energy facility cannot have an equity interest greater than 10 percent in any other renewable energy facility. However, for tax years beginning on or after January 1, 2015, an entity described in Iowa Code section 476C.1(6)*"b"*(4) or (5) may have an ownership interest in up to four solar energy conversion facilities described in Iowa Code section 476C.3(4)*"b"*(3).

42.28(2) *Tax credit certificate procedure.*

a. Tax credit application process. A producer or purchaser of a renewable energy facility must apply to the utilities board for the renewable energy tax credit. The application for the tax credit must be filed no later than 30 days after the close of the tax year for which the credit is applied. The information to be included in the application is set forth in 199—subrule 15.21(1). The utilities board will notify the department of the number of kilowatt-hours, standard cubic feet or British thermal units that were generated and purchased from an eligible facility or used for on-site consumption by the producer during the tax year for which the credit is applied.

b. Tax credit calculation. The department shall calculate the amount of the credit for which the applicant is eligible in accordance with subrules 42.28(3) and 42.28(4) and shall issue a tax credit certificate for that amount or shall notify the applicant in writing of its refusal to do so.

c. Tax credit certificate issuance. The tax credit certificate will include the taxpayer's name, address and federal identification number; the tax type for which the credit will be claimed; the amount of the credit; and the tax year for which the credit may be claimed. In addition, the tax credit certificate will include a place for the name and tax identification number of a transferee and the amount of the tax credit certificate, as provided in subrule 42.28(5). Once a tax credit certificate is issued pursuant to Iowa Code chapter 476C, it shall not be terminated or rescinded.

d. Taxpayers that are partnerships, limited liability companies, S corporations, or estates or trusts. If the taxpayer is a partnership, limited liability company, S corporation, or estate or trust requesting a credit for individual or corporation income tax, the tax credit certificate will be issued to the partners, members, shareholders or beneficiaries based on the partner's, member's, shareholder's or beneficiary's pro rata share of earnings of the partnership, limited liability company, S corporation, or estate or trust, except when the taxpayer is eligible to receive renewable electricity production tax credits authorized under Section 45 of the Internal Revenue Code. In cases where the taxpayer is eligible to receive renewable electricity production tax credits under Section 45 of the Internal Revenue Code, the partnership, limited liability company or S corporation may designate the amount of the tax credit to be allocated to each partner, member or shareholder. In addition, if a taxpayer is a partnership, limited liability company, S corporation, or estate or trust that is eligible to receive renewable electricity production tax credits under Section 45 of the Internal Revenue Code, the taxpayer may distribute the tax credit to an equity holder or beneficiary as a liquidating distribution, or portion thereof, of an equity holder's interest in the partnership, limited liability company or S corporation or of the beneficiary's interest in the estate or trust.

e. Carryforward. To claim the tax credit, the taxpayer must include the tax credit certificate with the tax return for the tax period set forth on the certificate. Any tax credit in excess of the tax liability may be carried forward for seven years or until it is used, whichever is the earlier.

42.28(3) *Limitations.*

a. Energy production. Of the maximum amount of energy production capacity equivalent for biogas recovery facilities, biomass conversion facilities, methane gas recovery facilities, solar energy conversion facilities and refuse conversion facilities:

(1) No single facility may be allocated more than ten megawatts of nameplate generating capacity or energy production capacity equivalent.

(2) For tax years beginning on or after January 1, 2015, ten megawatts of nameplate generating capacity or energy production capacity equivalent shall be reserved for solar energy conversion facilities described in Iowa Code section 476C.3(4)*"b"*(3) that have a generating capacity of one and one-half megawatts or less.

(3) For tax years, beginning on or after January 1, 2014, 55 billion British thermal units of heat for a commercial purpose shall be reserved annually for an eligible facility that is a refuse conversion facility for processed, engineered fuel from a multicounty solid waste management planning area.

(4) For tax years beginning on or after January 1, 2014, the maximum annual amount of energy production capacity for a single refuse conversion facility is 55 billion British thermal units of heat for a commercial purpose.

b. Related persons. The credit is not allowed for any kilowatt-hours, standard cubic feet or British thermal units that are purchased from an eligible facility by a related person. Persons shall be treated as related to each other if either person owns an 80 percent or more equity interest in the other person.

c. Operation. The facility must be operational within 30 months after approval was given by the utilities board, unless a 12-month extension is granted by the utilities board as provided in subrule 42.28(1).

d. Prohibited for persons that have received a credit under Iowa Code chapter 476B. A person that has received a wind energy production tax credit pursuant to Iowa Code chapter 476B may not be issued a renewable energy tax credit certificate.

e. Ten-year award limitation. The credit is allowed for a ten-year period beginning on the date the purchaser first purchases renewable energy from a qualified facility or on the date the qualified facility first began producing renewable energy for on-site consumption. For example, if a renewable energy facility first began producing energy for on-site consumption on April 1, 2006, the credit can be claimed for kilowatt-hours, standard cubic feet or British thermal units generated and used for on-site consumption by the producer between April 1, 2006, and March 31, 2016. Tax credit certificates cannot be issued for renewable energy purchased or produced for on-site consumption after December 31, 2027.

42.28(4) *Computation of the credit.* The renewable energy tax credit equals 1½ cents per kilowatt-hour of electricity, or $1.44 per 1000 standard cubic feet of hydrogen fuel, or $4.50 per 1

million British thermal units of methane gas or other biogas used to generate electricity, or $4.50 per 1 million British thermal units of heat for a commercial purpose generated by and purchased from an eligible renewable energy facility or used for on-site consumption by the producer during the tax year. For the first tax year in which the credit is applied, the kilowatt-hours, standard cubic feet or British thermal units generated by and purchased from the facility or used for on-site consumption by the producer may exceed 12 months if the facility was operational for fewer than 12 months in its initial year of operation.

EXAMPLE: A qualified wind energy production facility was placed in service on April 1, 2006, and the taxpayer files on a calendar-year basis. The first year for which the credit can be claimed is the year ending December 31, 2007, since that is the first tax year that began on or after July 1, 2006. The credit for the 2007 tax year can include electricity generated and purchased or used for on-site consumption by the producer between April 1, 2006, and December 31, 2007.

42.28(5) *Transfer of the renewable energy tax credit certificate.*

a. One-transfer limitation. The renewable energy tax credit certificate may be transferred once to any person or entity. A decision between a producer and purchaser of renewable energy regarding who may claim the tax credit is not considered a transfer.

b. Transfer process—information required. Within 30 days of transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the department, along with a statement which contains the transferee's name, address and tax identification number; the amount of the tax credit being transferred; the value of any consideration provided by the transferee to the transferor; and any other information required by the department. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee, the department will issue a replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company, S corporation, or estate or trust claiming the credit for individual or corporation income tax, the transferee shall provide a list of the partners, members, shareholders or beneficiaries and information on how the renewable energy tax credit should be divided among the partners, members, shareholders or beneficiaries. The transferee shall also provide the tax identification numbers and addresses of the partners, members, shareholders or beneficiaries. The replacement tax credit certificate must contain the same information as that on the original tax credit certificate and must have the same effective taxable year and the same expiration date as the original tax credit certificate. The replacement tax credit certificate may reflect a different tax type than the original tax credit certificate.

c. Tax year. The transferee may use the amount of the tax credit for any tax year for which the original transferor could have claimed the tax credit.

d. Consideration. Any consideration received for the transfer of the tax credit certificate shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit certificate shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

42.28(6) *Small wind innovation zones.* Effective for tax years beginning on or after January 1, 2009, an owner of a small wind energy system operating within a small wind innovation zone which has been approved by the Iowa utilities board is eligible for the renewable energy tax credit. The administrative rules of the Iowa utilities board for the certification of eligibility for owners of small wind energy systems operating within a small wind innovation zone may be found in rule 199—15.22(476).

42.28(7) *Appeals.* If the department refuses to issue the tax credit certificate, the taxpayer shall be notified in writing, and the taxpayer will have 60 days from the date of denial to file a protest in accordance with rule 701—7.8(17A).

This rule is intended to implement Iowa Code section 422.11J and Iowa Code chapter 476C as amended by 2015 Iowa Acts, chapter 124, and 2016 Iowa Acts, House File 2468.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9876B**, IAB 11/30/11, effective 1/4/12; **ARC 0251C**, IAB 8/8/12, effective 9/12/12; **ARC 1665C**, IAB 10/15/14, effective 11/19/14; **ARC 2772C**, IAB 10/12/16, effective 11/16/16]

701—42.29(15) High quality job creation program. Effective for tax periods ending on or after July 1, 2005, for programs approved on or after July 1, 2005, but before July 1, 2009, a business which

qualifies under the high quality job creation program is eligible to receive tax credits. The high quality job creation program replaces the new jobs and income program and the new capital investment program. An eligible business under the high quality job creation program must be approved by the Iowa department of economic development and meet the qualifications of Iowa Code section 15.329. The administrative rules for the high quality job creation program for the Iowa department of economic development may be found at 261—Chapter 68.

The high quality job creation program was repealed on July 1, 2009, and has been replaced with the high quality jobs program. See rule 701—42.42(15) for information on the investment tax credit and additional research activities credit under the high quality jobs program. Any investment tax credit and additional research activities credit earned by businesses approved under the high quality job creation program prior to July 1, 2009, remains valid and can be claimed on tax returns filed after July 1, 2009.

42.29(1) *Research activities credit.* An eligible business approved under the high quality job creation program is eligible for an additional research activities credit as described in 701—subrule 52.7(4).

Research activities allowable for the Iowa research activities credit include expenses related to the development and deployment of innovative renewable energy generation components manufactured or assembled in Iowa; such expenses related to the development and deployment of innovative renewable energy generation components are not eligible for the federal credit for increasing research activities. For purposes of this subrule, innovative renewable energy generation components do not include components with more than 200 megawatts in installed effective nameplate generating capacity. The research activities credit related to renewable energy generation components under the high quality job creation program and the enterprise zone program shall not exceed $1 million in the aggregate.

These expenses related to the development and deployment of innovative renewable energy generation components are applicable only to the additional research activities credit set forth in this subrule and are not applicable to the research activities credit set forth in subrule 42.11(3), paragraphs *"a"* and *"b."* The research activities credit is subject to the threshold amounts of qualifying investment set forth in Iowa department of economic development 261—subrule 68.4(7).

42.29(2) *Investment tax credit.*

a. General rule. An eligible business can claim an investment tax credit equal to a percentage of the new investment directly related to new jobs created by the location or expansion of an eligible business. The percentage is equal to the amount provided in Iowa department of economic development 261—subrule 68.4(7). New investment directly related to new jobs created by the location or expansion of an eligible business includes the following:

(1) The cost of machinery and equipment, as defined in Iowa Code section 427A.1(1), paragraphs *"e"* and *"j,"* purchased for use in the operation of the eligible business. The purchase price shall be depreciated in accordance with generally accepted accounting principles.

(2) The purchase price of real property and any buildings and structures located on the real property.

(3) The cost of improvements made to real property which is used in the operation of the eligible business.

In addition, certain lease payments made by eligible businesses to a third-party developer will be considered to be new investment for purposes of computing the investment tax credit. The eligible business shall enter into a lease agreement with the third-party developer for a minimum of five years. The investment tax credit is based on the annual base rent paid to a third-party developer by the eligible business for a period not to exceed ten years. The total costs of the annual base rent payments for the ten-year period cannot exceed the cost of the land and the third-party developer's cost to build or renovate the building used by the eligible business. The annual base rent is defined as the total lease payment less taxes, insurance and operating and maintenance expenses.

The investment tax credit can be claimed in the tax year in which the qualifying assets are placed in service. The investment tax credit will be amortized over a five-year period. Any credit in excess of the tax liability for the tax period may be carried forward seven years or until used, whichever is the earlier.

EXAMPLE: An eligible business which files tax returns on a calendar-year basis earned $100,000 of investment tax credits for new investment made in 2006. The business can claim $20,000 of investment tax credits for each of the years from 2006 through 2010. The $20,000 of investment tax credit that

can be claimed in 2006 can be carried forward to the 2007-2013 tax years if the entire credit cannot be claimed on the 2006 return. Similarly, the $20,000 investment tax credit that can be claimed in 2007 can be carried forward to the 2008-2014 tax years if the entire credit cannot be claimed on the 2007 return.

If the business is a partnership, S corporation, limited liability company, cooperative organized under Iowa Code chapter 501 and filing as a partnership for federal tax purposes, or estate or trust electing to have the income taxed directly to an individual, an individual may claim the credit. The amount of the credit claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, S corporation, limited liability company, cooperative organized under Iowa Code chapter 501 and filing as a partnership for federal tax purposes, or estate or trust electing to have the income taxed directly to an individual.

b. Investment tax credit—value-added agricultural products or biotechnology-related processes. An eligible business whose project primarily involves the production of value-added agricultural products or uses biotechnology-related processes may elect to receive a refund for all or a portion of an unused investment tax credit. An eligible business includes a cooperative described in Section 521 of the Internal Revenue Code whose project primarily involves the production of ethanol.

Eligible businesses that elect to receive a refund shall apply to the Iowa department of economic development for tax credit certificates between May 1 and May 15 of each fiscal year through the fiscal year ending June 30, 2009. The election to receive a refund of all or a portion of an unused investment tax credit is no longer available beginning with the fiscal year ending June 30, 2010. Only those businesses that have completed projects before the May 1 filing date may apply for a tax credit certificate. The Iowa department of economic development shall not issue tax credit certificates for more than $4 million during a fiscal year to eligible businesses for this program and the enterprise zone program described in subrule 42.14(2). If applications are received for more than $4 million, the applicants shall receive certificates for a prorated amount.

The economic development authority shall issue tax credit certificates within a reasonable period of time. Tax credit certificates are valid for the tax year following project completion. The tax credit certificate must be included with the tax return for the tax year during which the tax credit is claimed. The tax credit certificate shall not be transferred, except for a cooperative described in Section 521 of the Internal Revenue Code whose project primarily involves the production of ethanol, as provided in subrule 42.14(2). For value-added agricultural projects involving ethanol, the cooperative must submit a list of its members and the share of each member's interest in the cooperative. The economic development authority shall issue a tax credit certificate to each member on the list.

c. Repayment of benefits. If an eligible business fails to maintain the requirements of the high quality job creation program, the taxpayer may be required to repay all or a portion of the tax incentives taken on Iowa returns. Irrespective of the fact that the statute of limitations to assess the taxpayer for repayment of the tax credits may have expired, the department may proceed to collect the tax incentives forfeited by failure of the eligible business to maintain the requirements of the high quality job creation program because the repayment is a recovery of an incentive, rather than an adjustment to the taxpayer's tax liability. Details on the calculation of the repayment can be found in 261—subrule 187.5(4) of the administrative rules of the economic development authority. If the business is a partnership, limited liability company, S corporation, estate or trust where the income of the taxpayer is taxed to the individual owner(s) of the business, the department may proceed to collect the tax incentives against the partners, members, shareholders or beneficiaries to whom the tax incentives were passed through. See Decision of the Administrative Law Judge in *Damien & Colette Trebilcock, et al.,* Docket No. 11DORF 042-044, June 11, 2012.

An eligible business in the high quality job creation program may also be required to repay all or a portion of the tax incentives received on Iowa returns if the eligible business experiences a layoff of employees in Iowa or closes any of its facilities in Iowa.

If, within five years of purchase, the eligible business sells, disposes of, razes, or otherwise renders unusable all or a part of the land, buildings, or other existing structures for which a tax credit was claimed under this subrule, the income tax liability of the eligible business shall be increased by one of the following amounts:

(1) One hundred percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within one full year after being placed in service.

(2) Eighty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within two full years after being placed in service.

(3) Sixty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within three full years after being placed in service.

(4) Forty percent of the tax credit claimed if the property ceases to be eligible for the tax credit within four full years after being placed in service.

(5) Twenty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within five full years after being placed in service.

42.29(3) *Determination of tax credit amounts.* The amount of tax credit claimed under the high quality job creation program shall be based on the number of high quality jobs created and the amount of qualifying investment made as determined by the Iowa department of economic development.

a. If the high quality jobs have a starting wage, including benefits, equal to or greater than 130 percent of the average county wage but less than 160 percent of the average county wage, see Iowa department of economic development 261—paragraph 68.4(7)*"a"* for the amount of tax credits that may be claimed.

b. If the high quality jobs have a starting wage, including benefits, equal to or greater than 160 percent of the average county wage, see Iowa department of economic development 261—paragraph 68.4(7)*"b"* for the amount of tax credits that may be claimed.

c. An eligible business approved under the high quality job creation program is not eligible for the wage-benefits tax credit set forth in rule 701—42.26(15I,422).

This rule is intended to implement Iowa Code sections 15.326 to 15.337.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10; **ARC 1744C**, IAB 11/26/14, effective 12/31/14]

701—42.30(15E,422) Economic development region revolving fund tax credit. Effective for tax years ending on or after July 1, 2005, but beginning before January 1, 2010, a taxpayer who makes a contribution to an economic development region revolving fund may claim a tax credit, subject to the availability of the credit. The tax credit is equal to 20 percent of a taxpayer's contribution to the economic development region revolving fund approved by the Iowa department of economic development. The administrative rules for the economic development region revolving fund tax credit for the Iowa department of economic development may be found at 261—Chapter 32. The tax credit is repealed for tax years beginning on or after January 1, 2010.

The total amount of economic development region revolving fund tax credits available shall not exceed $2 million per fiscal year. The tax credit shall not be carried back to a tax year prior to the year in which the taxpayer redeems the credit. The economic development region revolving fund tax credit is not transferable to any other taxpayer.

Any tax credit in excess of the tax liability for the tax year may be credited to the tax liability for the following ten years or until used, whichever is the earlier.

If a taxpayer is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement Iowa Code sections 15E.232 and 422.11K as amended by 2010 Iowa Acts, Senate File 2380.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10]

701—42.31(422) Early childhood development tax credit. Effective for tax years beginning on or after January 1, 2006, taxpayers may claim a tax credit equal to 25 percent of the first $1,000 of expenses paid to others for early childhood development for each dependent three to five years of age. The credit is available only to taxpayers whose net income is less than $45,000. If a taxpayer claims the early childhood development tax credit, the taxpayer cannot claim the child and dependent care credit

described in rule 701—42.15(422). The early childhood development tax credit is refundable to the extent that the credit exceeds the taxpayer's income tax liability. For the tax year beginning in the 2006 calendar year only, amounts paid for early childhood development expenses in November and December of 2005 shall be considered paid in 2006 for purposes of computing the credit.

For married taxpayers who elect to file separately on a combined form or elect to file separate returns for Iowa tax purposes, the combined income of the taxpayers must be less than $45,000 to be eligible for the credit. If the combined income is less than $45,000, the early childhood development tax credit shall be prorated to each spouse in the proportion that each spouse's respective net income bears to the total combined income.

42.31(1) *Expenses eligible for the credit.* The following expenses qualify for the early childhood development tax credit, to the extent they are paid during the time period that a dependent is either three, four or five years of age:

a. Expenses for services provided by a preschool, as defined in Iowa Code section 237A.1. The preschool may only provide services for periods of time not exceeding three hours per day.

b. Books that improve child development, including textbooks, music books, art books, teacher editions and reading books.

c. Expenses paid for instructional materials required to be used in a child development or educational lesson activity. These materials include, but are not limited to, paper, notebooks, pencils, and art supplies. In addition, software and toys which are directly and primarily used for educational or learning purposes are considered instructional materials.

d. Expenses paid for lesson plans and curricula.

e. Expenses paid for child development and educational activities outside the home. These activities include, but are not limited to, drama, art, music and museum activities, including the entrance fees for such activities.

42.31(2) *Expenses not eligible for the credit.* The following expenses do not qualify for the early childhood development tax credit:

a. Any expenses paid to a preschool once a dependent reaches the age of six.

b. Expenses relating to food, lodging, membership fees, or other nonacademic expenses relating to child development and educational activities outside the home.

c. Expenses related to services, materials, or activities for the teaching of religious tenets, doctrines, or worship, in cases where the purpose of the teaching is to inculcate the religious tenets, doctrines, or worship.

This rule is intended to implement Iowa Code section 422.12C.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10]

701—42.32(422) School tuition organization tax credit. Effective for the tax year beginning on or after January 1, 2006, but beginning before January 1, 2007, a school tuition organization tax credit is available which is equal to 65 percent of the amount of the voluntary cash contributions made by a taxpayer to a school tuition organization. For tax years beginning on or after January 1, 2007, the school tuition organization tax credit is available which is equal to 65 percent of the amount of voluntary cash or noncash contributions made by a taxpayer to a school tuition organization. There are numerous federal revenue regulations, rulings, court cases and other provisions relating to the determination of the value of a noncash contribution, and these are equally applicable to the determination of the amount of a school tuition organization tax credit for tax years beginning on or after January 1, 2007.

42.32(1) *Definitions.* The following definitions are applicable to this rule:

"Certified enrollment" means the enrollment at schools served by school tuition organizations as of October 1, or the first Monday in October if October 1 falls on a Saturday or Sunday, of the appropriate year.

"Contribution" means a voluntary cash or noncash contribution to a school tuition organization that is not used for the direct benefit of any dependent of the taxpayer or any other student designated by the taxpayer.

"Eligible student" means a student residing in Iowa who is a member of a household whose total annual income during the calendar year prior to the school year in which the student receives a tuition grant from a school tuition organization does not exceed an amount equal to three times the most recently published federal poverty guidelines in the Federal Register by the United States Department of Health and Human Services.

"Qualified school" means a nonpublic elementary or secondary school in Iowa which is accredited under Iowa Code section 256.11, including a prekindergarten program for students who are five years of age by September 15 of the appropriate year, and adheres to the provisions of the federal Civil Rights Act of 1964 and Iowa Code chapter 216, and which is represented by only one school tuition organization.

"School tuition organization" means a charitable organization in Iowa that is exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code and that does all of the following:

1. Allocates at least 90 percent of its annual revenue in tuition grants for children to allow them to attend a qualified school of their parents' choice.
2. Awards tuition grants only to children who reside in Iowa.
3. Provides tuition grants to students without limiting availability to students of only one school.
4. Provides tuition grants only to eligible students.
5. Prepares an annual financial statement certified by a public accounting firm.

"Tuition grant" means a grant to a student to cover all or part of the student's tuition at a qualified school.

42.32(2) *Initial registration.* In order for contributions to a school tuition organization to qualify for the credit, the school tuition organization must initially register with the department. The following information must be provided with this initial registration:

a. Verification from the Internal Revenue Service that Section 501(c)(3) status was granted and that the school tuition organization is exempt from federal income tax.

b. A list of all qualified schools that the school tuition organization serves.

c. The names and addresses of all the members of the board of directors of the school tuition organization.

Once the school tuition organization is registered with the department, it is not required to subsequently register unless there is a change in the qualified schools that the organization serves. The school tuition organization must notify the department in writing of any changes in the qualified schools it serves.

42.32(3) *Participation forms.* Each qualified school that is served by a school tuition organization must annually submit a participation form to the department by November 1. The following information must be provided with this participation form:

a. The certified enrollment of the qualified school as of October 1, or the first Monday in October if October 1 falls on a Saturday or Sunday.

b. The name of the school tuition organization that represents the qualified school.

For the tax year beginning in the 2006 calendar year only, each qualified school served by a school tuition organization must submit to the department a participation form postmarked on or before August 1, 2006, which provides the certified enrollment as of the third Friday of September 2005, along with the name of the school tuition organization that represents the qualified school.

42.32(4) *Authorization to issue tax credit certificates.*

a. By December 1 of each year, the department will authorize school tuition organizations to issue tax credit certificates for the following tax year. For the tax year beginning in the 2006 calendar year only, the department, by September 1, 2006, will authorize school tuition organizations to issue tax credit certificates for the 2006 calendar year only. The total amount of tax credit certificates that may be authorized is $2.5 million for the 2006 calendar year, $5 million for the 2007 calendar year, $7.5 million for the 2008 through 2011 calendar years, $8.75 million for the 2012 and 2013 calendar years, and $12 million for 2014 and subsequent calendar years.

b. The amount of authorized tax credit certificates for each school tuition organization is determined by dividing the total amount of tax credit available by the total certified enrollment of all qualified participating schools. This result, which is the per-student tax credit, is then multiplied by the

certified enrollment of each school tuition organization to determine the tax credit authorized to each school tuition organization.

EXAMPLE: For determining the authorized tax credits for the 2008 calendar year, if the certified enrollment of each qualified school in Iowa, as provided to the department by November 1, 2007, was 37,500, the per-student tax credit would be $200 ($7.5 million divided by 37,500). If a school tuition organization located in Scott County represents four qualified schools with a certified enrollment of 1,400 students, the school tuition organization would be authorized to issue $280,000 ($200 times 1,400) of tax credit certificates for the 2008 calendar year. The department would notify this school tuition organization by December 1, 2007, of the authorization to issue $280,000 of tax credit certificates for the 2008 calendar year. This authorization would allow the school tuition organization to solicit contributions totaling $430,769 ($280,000 divided by 65%) during the 2008 calendar year which would be eligible for the tax credit.

42.32(5) *Issuance of tax credit certificates.* The school tuition organization shall issue tax credit certificates to each taxpayer who made a cash or noncash contribution to the school tuition organization. The tax credit certificate, which will be designed by the department, will contain the name, address and tax identification number of the taxpayer, the amount and date that the contribution was made, the amount of the credit, the tax year that the credit may be applied, the school tuition organization to which the contribution was made, and the tax credit certificate number.

For tax years beginning on or after July 1, 2009, a tax credit certificate may be issued to corporation income taxpayers. For tax years beginning on or after January 1, 2013, a tax credit certificate may be issued to a partnership, limited liability company, S corporation, estate or trust. The amount of credit claimed by an individual shall be based on the pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, estate or trust.

42.32(6) *Claiming the tax credit.* The taxpayer must include the tax credit certificate with the tax return for which the credit is claimed. Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is the earlier.

a. The taxpayer may not claim an itemized deduction for charitable contributions for Iowa income tax purposes for the amount of the contribution made to the school tuition organization.

b. Married taxpayers who file separate returns or file separately on a combined return must allocate the school tuition organization tax credit to each spouse in the proportion that each spouse's respective net income bears to the total combined net income. Nonresidents or part-year residents of Iowa must determine the school tuition organization tax credit in the ratio of their Iowa source net income to their total source net income. In addition, if nonresidents or part-year residents of Iowa are married and elect to file separate returns or to file separately on a combined return, the school tuition organization tax credit must be allocated between the spouses in the ratio of each spouse's Iowa source net income to the combined Iowa source net income.

42.32(7) *Reporting requirements.* Each school tuition organization that issues tax credit certificates must report to the department, postmarked by January 12 of each tax year, the following information:

a. The names and addresses of all the members of the board of directors of the school tuition organization, along with the name of the chairperson of the board.

b. The total number and dollar value of contributions received by the school tuition organization for the previous tax year.

c. The total number and dollar value of tax credit certificates issued by the school tuition organization for the previous tax year.

d. A list of each taxpayer who received a tax credit certificate for the previous tax year, including the amount of the contribution and the amount of tax credit issued to each taxpayer for the previous tax year. This list should also include the tax identification number of the taxpayer and the tax credit certificate number for each certificate.

e. The total number of children utilizing tuition grants for the school year in progress as of January 12, along with the total dollar value of the tuition grants.

f. The name and address of each qualified school represented by the school tuition organization at which tuition grants are being utilized for the school year in progress.

g. The number of tuition grant students and the total dollar value of tuition grants being utilized for the school year in progress at each qualified school served by the school tuition organization.

This rule is intended to implement Iowa Code section 422.11S as amended by 2013 Iowa Acts, House File 625.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9876B**, IAB 11/30/11, effective 1/4/12; **ARC 1102C**, IAB 10/16/13, effective 11/20/13; **ARC 1744C**, IAB 11/26/14, effective 12/31/14]

701—42.33(422) E-85 gasoline promotion tax credit. Effective for tax years beginning on or after January 1, 2006, a retail dealer of gasoline may claim an E-85 gasoline promotion tax credit. "E-85 gasoline" means ethanol blended gasoline formulated with a minimum percentage of between 70 percent and 85 percent of volume of ethanol, if the formulation meets the standards provided in Iowa Code section 214A.2. For purposes of this rule, tank wagon sales are considered retail sales. The credit is calculated on Form IA 135. The credit is calculated by multiplying the total number of E-85 gallons sold by the retail dealer during the tax year by the following designated rates:

Calendar years 2006, 2007 and 2008	25 cents
Calendar years 2009 and 2010	20 cents
Calendar year 2011	10 cents
Calendar years 2012 through 2017	16 cents

A taxpayer may claim the E-85 gasoline promotion tax credit even if the taxpayer also claims the ethanol blended gasoline tax credit provided in rule 701—42.20(422) for gallons sold prior to January 1, 2009, or the ethanol promotion tax credit provided in rule 701—42.39(422) for gallons sold on or after January 1, 2009, for the same tax year for the same ethanol gallons.

Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

EXAMPLE: A taxpayer operated one retail motor fuel site in 2008 and sold 200,000 gallons of gasoline, of which 160,000 gallons was ethanol blended gasoline. Of these 160,000 gallons, 1,000 gallons was E-85 gasoline. Taxpayer may claim the E-85 gasoline promotion tax credit on the 1,000 gallons of E-85 gasoline sold during 2008. Taxpayer is also entitled to claim the ethanol blended gasoline tax credit of two and one-half cents multiplied by 40,000 gallons, since this constitutes the gallons in excess of 60 percent of the total gasoline gallons sold for the 2008 tax year.

42.33(1) *Fiscal year filers.* For taxpayers whose tax year is not on a calendar-year basis, the taxpayer may compute the tax credit on the gallons of E-85 gasoline sold during the year using the designated rates as shown above. Because the tax credit is repealed on January 1, 2018, a taxpayer whose tax year ends prior to December 31, 2017, may continue to claim the tax credit in the following tax year for any E-85 gallons sold through December 31, 2017. For a retail dealer whose tax year is not on a calendar-year basis and who did not claim the E-85 credit on the previous return, the dealer may claim the credit for the current tax year for the period beginning on January 1 of the previous tax year until the last day of the previous tax year.

See 701—subrule 52.30(1) for examples illustrating how this subrule is applied.

42.33(2) *Allocation of credit to owners of a business entity.* If a taxpayer claiming the E-85 ethanol promotion tax credit is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement Iowa Code section 422.11O as amended by 2011 Iowa Acts, Senate File 531.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9821B**, IAB 11/2/11, effective 12/7/11]

701—42.34(422) Biodiesel blended fuel tax credit. Effective for tax years beginning on or after January 1, 2006, a retail dealer of biodiesel blended fuel may claim a biodiesel blended fuel tax credit. "Biodiesel blended fuel" means a blend of biodiesel with petroleum-based diesel fuel which meets the standards

provided in Iowa Code section 214A.2. The biodiesel blended fuel must be formulated with a minimum percentage of 2 percent by volume of biodiesel, if the formulation meets the standards provided by Iowa Code section 214A.2, to qualify for the tax credit for gallons sold on or after January 1, 2006, but before January 1, 2013. For gallons sold on or after January 1, 2013, but before January 1, 2018, the biodiesel blended fuel must be formulated with a minimum percentage of 5 percent by volume of biodiesel, if the formulation meets the standards provided by Iowa Code section 214A.2, to qualify for the tax credit. In addition, of the total gallons of diesel fuel sold by the retail dealer, 50 percent or more must be biodiesel blended fuel to be eligible for the tax credit for tax years beginning prior to January 1, 2009. For tax years beginning on or after January 1, 2009, but before January 1, 2012, the biodiesel blended fuel tax credit is calculated separately for each retail motor fuel site for which 50 percent or more of the total gallons of diesel fuel sold at the motor fuel site was biodiesel blended fuel. For tax years beginning on or after January 1, 2012, the requirement that 50 percent of all diesel fuel gallons sold be biodiesel gallons to be eligible for the tax credit is eliminated.

The tax credit equals three cents multiplied by the qualifying number of biodiesel blended fuel gallons sold by the taxpayer during the tax year for gallons sold through December 31, 2011. For gallons sold during the 2012 calendar year, the tax credit equals the sum of two cents multiplied by the qualifying number of biodiesel blended fuel gallons that have a minimum percentage of 2 percent by volume of biodiesel but less than 5 percent by volume of biodiesel and four and one-half cents multiplied by the qualifying number of biodiesel blended fuel gallons that have a minimum percentage of 5 percent by volume of biodiesel. For gallons sold during the 2013 to 2017 calendar years, the tax credit equals four and one-half cents multiplied by the qualifying number of biodiesel blended fuel gallons that have a minimum percentage of 5 percent by volume of biodiesel. In determining the minimum percentage by volume of biodiesel, the department will take into account reasonable variances due to testing and other limitations. For purposes of this rule, tank wagon sales are considered retail sales. The credit is calculated on Form IA 8864.

Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

EXAMPLE: A taxpayer operated four retail motor fuel sites during 2008 and sold a combined total at all four sites of 100,000 gallons of diesel fuel, of which 55,000 gallons was biodiesel blended fuel containing a minimum percentage of 2 percent by volume of biodiesel. Because 50 percent or more of the diesel fuel sold was biodiesel blended fuel, the taxpayer may claim the biodiesel blended fuel tax credit totaling $1,650, which is 55,000 gallons multiplied by three cents.

EXAMPLE: A taxpayer operated two retail motor fuel sites during 2008, and each site sold 40,000 gallons of diesel fuel. One site sold 25,000 gallons of biodiesel blended fuel, and the other site sold 10,000 gallons of biodiesel blended fuel. The taxpayer would not be eligible for the biodiesel blended fuel tax credit because only 35,000 gallons of the total 80,000 gallons, or 43.75 percent of the total diesel fuel gallons sold, was biodiesel blended fuel. The 50 percent requirement is based on the aggregate number of diesel fuel gallons sold by the taxpayer, and the fact that one retail motor fuel site met the 50 percent requirement does not allow the taxpayer to claim the biodiesel blended fuel tax credit for the 2008 tax year. If the facts in this example had occurred during the 2009 tax year, the taxpayer could claim a biodiesel blended fuel tax credit totaling $750, which is 25,000 gallons multiplied by three cents, since one of the retail motor fuel sites met the 50 percent biodiesel blended fuel requirement.

42.34(1) *Fiscal year filers.* Taxpayers whose tax year is not on a calendar-year basis and whose tax year ends before December 31, 2006, may compute the tax credit on the gallons of biodiesel blended fuel sold during the period from January 1, 2006, through the end of the tax year, provided that 50 percent of all diesel fuel sold during that period was biodiesel blended fuel. Because the tax credit is repealed on January 1, 2018, a taxpayer whose tax year ends prior to December 31, 2017, may continue to claim the tax credit in the following tax year for any biodiesel blended fuel sold through December 31, 2017.

See 701—subrule 52.31(1) for examples illustrating how this subrule is applied.

42.34(2) *Allocation of credit to owners of a business entity.* If a taxpayer claiming the biodiesel blended fuel tax credit is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The

amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement Iowa Code section 422.11P as amended by 2011 Iowa Acts, Senate Files 531 and 533.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9821B**, IAB 11/2/11, effective 12/7/11]

701—42.35(422) Soy-based transformer fluid tax credit. Effective for tax periods ending after June 30, 2006, and beginning before January 1, 2009, an electric utility may claim a soy-based transformer fluid tax credit. An electric utility, which is a public utility, city utility, or electric cooperative which furnishes electricity, may claim a credit equal to the costs incurred during the tax year for the purchase and replacement costs relating to the transition from using nonsoy-based transformer fluid to using soy-based transformer fluid.

42.35(1) *Eligibility requirements for the tax credit.* All of the following conditions must be met for the electric utility to qualify for the soy-based transformer fluid tax credit.

a. The costs must be incurred after June 30, 2006, and before January 1, 2009.

b. The costs must be incurred in the first 18 months of the transition from using nonsoy-based transformer fluid to using soy-based transformer fluid.

c. The soy-based transformer fluid must be dielectric fluid that contains at least 98 percent soy-based products.

d. The costs of the purchase and replacement must not exceed $2 per gallon of soy-based transformer fluid used in the transition.

e. The number of gallons used in the transition must not exceed 20,000 gallons per electric utility, and the total number of gallons eligible for the credit must not exceed 60,000 gallons in the aggregate.

f. The electric utility shall not deduct for Iowa income tax purposes the costs incurred in the transition to using soy-based transformer fluid which are deductible for federal income tax purposes.

42.35(2) *Applying for the tax credit.* An electric utility must apply to the department for the soy-based transformer fluid tax credit. The application for the tax credit must be filed no later than 30 days after the close of the tax year for which the credit is claimed. The application must include the following information:

a. A copy of the signed purchase agreement or other agreement to purchase soy-based transformer fluid.

b. The number of gallons of soy-based transformer fluid purchased during the tax year, along with the cost per gallon of each purchase made during the tax year.

c. The name, address, and tax identification number of the electric utility.

d. The type of tax for which the credit will be claimed, and the first year in which the credit will be claimed.

e. If the application is filed by a partnership, limited liability company, S corporation, or estate or trust requesting a credit for individual or corporation income tax, a list of the partners, members, shareholders or beneficiaries of the entity. This list shall include the name, address, tax identification number and pro rata share of earnings from the entity for each of the partners, members, shareholders or beneficiaries.

42.35(3) *Claiming the tax credit.* After the application is reviewed, the department will issue a tax credit certificate to the electric utility. The tax credit certificate will include the taxpayer's name, address and federal identification number, the tax type for which the credit will be claimed, the amount of the credit and the tax year for which the credit may be claimed. Once the tax credit certificate is issued, the credit may be claimed only against the type of tax reflected on the certificate. If the department refuses to issue the tax credit certificate, the taxpayer shall be notified in writing; and the taxpayer will have 60 days from the date of denial to file a protest in accordance with rule 701—7.8(17A).

If the taxpayer is a partnership, limited liability company, S corporation, or estate or trust requesting a credit for individual or corporation income tax, the tax credit certificate will be issued to the partners, members, shareholders or beneficiaries based on the partner's, member's, shareholder's or beneficiary's pro rata share of earnings of the partnership, limited liability company, S corporation, or estate or trust.

Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

This rule is intended to implement Iowa Code section 422.11R.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 0251C**, IAB 8/8/12, effective 9/12/12]

701—42.36(16,422) Agricultural assets transfer tax credit and custom farming contract tax credit.

42.36(1) *Agricultural assets transfer tax credit.* For tax years beginning on or after January 1, 2007, but before January 1, 2013, an owner of agricultural assets that rents assets to qualified beginning farmers may claim an agricultural assets transfer tax credit for Iowa individual income tax equal to 5 percent of the rental income received by the owner for cash rental agreements and 15 percent of the rental income received by the owner for commodity share agreements. Effective for tax years beginning on or after January 1, 2013, an owner of agricultural assets that rents assets to qualified beginning farmers may claim an agricultural assets transfer tax credit for Iowa individual income tax equal to 7 percent of the rental income received by the owner for cash rental agreements and 17 percent of the rental income received by the owner for commodity share agreements.

Also effective for tax years beginning on or after January 1, 2013, if the beginning farmer is a veteran, the credit is equal to 8 percent of the rental income received by the owner for cash rental agreements, and the credit is equal to 18 percent of the rental income received by the owner for commodity share agreements for the first year that the credit is allowed. However, the taxpayer may only claim 7 percent of the rental income for cash rental agreements and 17 percent of the rental income for commodity share agreements in subsequent years if the agreement is renewed or a new agreement is executed by the same parties. The administrative rules for the agricultural assets transfer tax credit for the Iowa finance authority may be found under 265—Chapter 44.

To qualify for the tax credit, an owner of agricultural assets must enter into a lease or rental agreement with a beginning farmer for a term of at least two years, but not more than five years. Both the owner of agricultural assets and the beginning farmer must meet certain qualifications set forth by the Iowa finance authority, and the beginning farmer must be eligible to receive financial assistance under Iowa Code section 16.75.

The Iowa finance authority will issue a tax credit certificate to the owner of agricultural assets which will include the name, address and tax identification number of the owner, the amount of the credit, and the tax period for which the credit may be applied. To claim the tax credit, the owner must include the tax credit certificate with the tax return for the tax period set forth on the certificate. The tax credit certificates will be issued on a first-come, first-served basis. For fiscal years beginning on or after July 1, 2009, but before July 1, 2013, the amount of tax credit certificates issued by the Iowa agricultural development authority for the agricultural assets transfer tax credit program cannot exceed $6 million. For fiscal years beginning on or after July 1, 2013, the amount of the tax credit certificates issued by the Iowa finance authority for the agricultural assets transfer tax credit program cannot exceed $8 million and the amount of the credit issued to an individual taxpayer cannot exceed $50,000. However, effective December 31, 2017, the amount of tax credits issued by the Iowa finance authority for the agricultural assets transfer tax credit shall revert back to $6 million.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is the earlier. However, for any agricultural assets transfer tax credits originally issued for tax years beginning on or after January 1, 2008, any credit in excess of the tax liability may be credited to the tax liability for the following ten years. The tax credit shall not be carried back to a tax year prior to the year in which the owner redeems the credit. The credit is not transferable to any other person other than the taxpayer's estate or trust upon the death of the taxpayer.

If an owner of agricultural assets is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

The lease or rental agreement may be terminated by either the owner or the beginning farmer. If the Iowa finance authority determines that the owner is not at fault for the termination, the authority

will not issue a tax credit certificate for subsequent years, but any prior tax credit certificates issued will be allowed. If the Iowa finance authority determines that the owner is at fault for the termination, any prior tax credit certificates will be disallowed. The amount of tax credits previously allowed will be recaptured, and the owner will be required to repay the entire amount of tax credits previously claimed on Iowa returns.

42.36(2) *Custom farming contract tax credit.* Effective for tax years beginning on or after January 1, 2013, a landowner that hires a beginning farmer to custom farm agricultural land in this state may claim a custom farming contract tax credit for Iowa individual income tax. The credit is equal to 7 percent of the value of the contract. If the beginning farmer is a veteran, the credit is equal to 8 percent of the value of the contract for the first year. However, the taxpayer may only claim 7 percent of the value of the contract in subsequent years if the agreement is renewed or a new agreement is executed by the same parties. The administrative rules for the custom farming contract tax credit for the Iowa finance authority may be found under 265—Chapter 44.

To qualify for the tax credit, the taxpayer must enter into a lease or rental agreement with a beginning farmer for a term of at least two years but not more than five years. Both the taxpayer and the beginning farmer must meet certain qualifications set forth by the Iowa finance authority, and the beginning farmer must be eligible to receive financial assistance under Iowa Code section 16.75.

The Iowa finance authority will issue a tax credit certificate to the taxpayer which will include the name, address and tax identification number of the owner, the amount of the credit, and the tax period for which the credit may be applied. To claim the tax credit, the owner must include the tax credit certificate with the tax return for the tax period set forth on the certificate. For fiscal years beginning on or after July 1, 2013, the amount of tax credit certificates issued by the Iowa finance authority for the custom farming contract tax credit program cannot exceed $4 million, and the credit certificates will be issued on a first-come, first-served basis. The amount of the credit issued to an individual taxpayer cannot exceed $50,000. However, effective December 31, 2017, the Iowa finance authority will no longer issue custom farming contract tax credits.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following ten years or until used, whichever is the earlier. The tax credit shall not be carried back to a tax year prior to the year in which the owner redeems the credit. The credit is not transferable to any other person other than the taxpayer's estate or trust upon the death of the taxpayer.

If the party entering into the custom farming contract with the beginning farmer is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

The custom farming contract may be terminated by either the taxpayer or the beginning farmer. If the Iowa finance authority determines that the taxpayer is not at fault for the termination, the authority will not issue a tax credit certificate for subsequent years, but any prior tax credit certificates issued will be allowed. If the Iowa finance authority determines that the taxpayer is at fault for the termination, any prior tax credit certificates will be disallowed. The amount of tax credits previously allowed will be recaptured, and the taxpayer will be required to repay the entire amount of tax credits previously claimed on Iowa returns.

This rule is intended to implement Iowa Code section 422.11M; 2014 Iowa Acts, Senate File 2328, sections 60 and 61, as amended by 2014 Iowa Acts, House File 2454; and 2014 Iowa Acts, Senate File 2328, sections 120 and 122.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 1138C**, IAB 10/30/13, effective 12/4/13; **ARC 1665C**, IAB 10/15/14, effective 11/19/14]

701—42.37(15,422) Film qualified expenditure tax credit. Effective for tax years beginning on or after January 1, 2007, a film qualified expenditure tax credit is available for individual income tax. The tax credit cannot exceed 25 percent of the taxpayer's qualified expenditures in a film, television, or video project registered with the film office of the Iowa department of economic development (IDED). The

film office may negotiate the amount of the tax credit. The administrative rules for the film qualified expenditure tax credit for IDED may be found at 261—Chapter 36.

42.37(1) *Qualified expenditures.* A qualified expenditure is a payment to an Iowa resident or an Iowa-based business for the sale, rental or furnishing of tangible personal property or services directly related to the registered project. The qualified expenditures include, but are not limited to, the following:

1. Aircraft.
2. Vehicles.
3. Equipment.
4. Materials.
5. Supplies.
6. Accounting services.
7. Animals and animal care services.
8. Artistic and design services.
9. Graphics.
10. Construction.
11. Data and information services.
12. Delivery and pickup services.
13. Labor and personnel. For limitations on the amount of labor and personnel expenditures, see Iowa department of economic development 261—paragraph 36.7(2)*"b."*
14. Lighting services.
15. Makeup and hairdressing services.
16. Film.
17. Music.
18. Photography.
19. Sound.
20. Video and related services.
21. Printing.
22. Research.
23. Site fees and rental.
24. Travel related to Iowa distant locations.
25. Trash removal and cleanup.
26. Wardrobe.

A detailed list of all qualified expenditures for each of these categories is available from the film office of IDED.

42.37(2) *Claiming the tax credit.* Upon completion of the registered project in Iowa, the taxpayer must submit, in a format approved by IDED prior to production, a listing of the qualified expenditures. Upon verification of the qualified expenditures, IDED will issue a tax credit certificate to the taxpayer. The certificate will list the taxpayer's name, address, and tax identification number; the date of project completion; the amount of the credit; the tax period for which the credit may be applied; and the type of tax for which the credit will be applied.

If the taxpayer is a partnership, limited liability company, S corporation, or estate or trust requesting a credit for individual or corporation income tax, the tax credit certificate will be issued to the partners, members, shareholders or beneficiaries based on each partner's, member's, shareholder's or beneficiary's pro rata share of earnings of the partnership, limited liability company, S corporation, or estate or trust.

To claim the tax credit, the taxpayer must include the tax credit certificate with the tax return for the tax period set forth on the certificate. Any tax credit in excess of the tax liability may be carried forward for five years or until the tax credit is used, whichever is the earlier. The tax credit cannot be carried back to a tax year prior to the year in which the taxpayer claimed the tax credit.

42.37(3) *Transfer of the film qualified expenditure tax credit.* The film qualified expenditure tax credit may be transferred no more than two times to any person or entity.

Within 90 days of transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the department of revenue, along with a statement which contains the transferee's

name, address and tax identification number and the amount of the tax credit being transferred. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee, the department of revenue will issue a replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company, S corporation, or estate or trust claiming the credit for individual or corporation income tax, the transferee shall provide a list of the partners, members, shareholders or beneficiaries and information on how the film qualified expenditure tax credit should be divided among the partners, members, shareholders or beneficiaries. The transferee shall also provide the tax identification numbers and addresses of the partners, members, shareholders or beneficiaries. The replacement tax credit certificate must contain the same information as that on the original tax credit certificate and must have the same effective taxable year as the original tax credit certificate. The replacement tax credit certificate may reflect a different tax type than the original tax credit certificate.

The transferee may use the amount of the tax credit for any tax year for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit certificate shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit certificate shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

42.37(4) *Repeal of film qualified expenditure tax credit.* The film qualified expenditure tax credit is repealed for tax years beginning on or after January 1, 2012. However, the credit is still available for tax years beginning prior to January 1, 2012, if the contract or agreement related to a film project was entered into on or before May 25, 2012.

This rule is intended to implement 2012 Iowa Acts, House File 2337, sections 38 to 40.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 0398C**, IAB 10/17/12, effective 11/21/12; **ARC 1744C**, IAB 11/26/14, effective 12/31/14]

701—42.38(15,422) Film investment tax credit. Effective for tax years beginning on or after January 1, 2007, a film investment tax credit is available for individual income tax. The tax credit cannot exceed 25 percent of the taxpayer's investment in a film, television, or video project registered with the film office of the Iowa department of economic development (IDED). The film office may negotiate the amount of the tax credit. The administrative rules for the film investment tax credit for IDED may be found at 261—Chapter 36.

42.38(1) *Claiming the tax credit.* Upon completion of the project in Iowa and verification of the investment in the project, IDED will issue a tax credit certificate to the taxpayer. The certificate will list the taxpayer's name, address, and tax identification number; the date of project completion; the amount of the credit; the tax period for which the credit may be applied; and the type of tax for which the credit will be applied.

If the taxpayer is a partnership, limited liability company, S corporation, or estate or trust requesting a credit for individual or corporation income tax, the tax credit certificate will be issued to the partners, members, shareholders or beneficiaries based on each partner's, member's, shareholder's or beneficiary's pro rata share of earnings of the partnership, limited liability company, S corporation, or estate or trust.

To claim the tax credit, the taxpayer must include the tax credit certificate with the tax return for the tax period set forth on the certificate. Any tax credit in excess of the tax liability may be carried forward for five years or until the tax credit is used, whichever is the earlier. The tax credit cannot be carried back to a tax year prior to the year in which the taxpayer claimed the tax credit. In addition, a taxpayer cannot claim the film investment tax credit for qualified expenditures for which the film expenditure tax credit set forth in rule 701—42.37(15,422) is claimed.

The total of all film investment tax credits for a particular project cannot exceed 25 percent of the qualified expenditures as set forth in subrule 42.37(1) for the particular project. If the amount of investment exceeds the qualified expenditures, the tax credit will be allocated proportionately. For example, if three investors each invested $100,000 in a project but the qualified expenditures in Iowa only totaled $270,000, each investor would receive a tax credit based on a $90,000 investment amount.

42.38(2) *Transfer of the film investment tax credit.* The film investment tax credit may be transferred no more than two times to any person or entity.

Within 90 days of transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the department of revenue, along with a statement which contains the transferee's name, address and tax identification number and the amount of the tax credit being transferred. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee, the department of revenue will issue a replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company, S corporation, or estate or trust claiming the credit for individual or corporation income tax, the transferee shall provide a list of the partners, members, shareholders or beneficiaries and information on how the film investment tax credit should be divided among the partners, members, shareholders or beneficiaries. The transferee shall also provide the tax identification numbers and addresses of the partners, members, shareholders or beneficiaries. The replacement tax credit certificate must contain the same information as that on the original tax credit certificate and must have the same effective taxable year as the original tax credit certificate. The replacement tax credit certificate may reflect a different tax type than the original tax credit certificate.

The transferee may use the amount of the tax credit for any tax year for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit certificate shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit certificate shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

42.38(3) *Repeal of film investment tax credit.* The film investment tax credit is repealed for tax years beginning on or after January 1, 2012. However, the credit is still available for tax years beginning prior to January 1, 2012, if the contract or agreement related to a film project was entered into on or before May 25, 2012.

This rule is intended to implement 2012 Iowa Acts, House File 2337, sections 38 to 40.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 0398C**, IAB 10/17/12, effective 11/21/12; **ARC 1744C**, IAB 11/26/14, effective 12/31/14]

701—42.39(422) Ethanol promotion tax credit. Effective for tax years beginning on or after January 1, 2009, a retail dealer of gasoline may claim an ethanol promotion tax credit. For purposes of this rule, tank wagon sales are considered retail sales. The ethanol promotion tax credit is computed on Form IA 137.

42.39(1) *Definitions.* The following definitions are applicable to this rule:

"Biodiesel gallonage" means the total number of gallons of biodiesel which the retail dealer sells from motor fuel pumps during a determination period. For example, 5,000 gallons of biodiesel blended fuel with a 2 percent by volume of biodiesel sold during a determination period results in a biodiesel gallonage of 100 (5,000 times 2%).

"Biofuel distribution percentage" means the sum of the retail dealer's total ethanol gallonage plus the retail dealer's total biodiesel gallonage expressed as a percentage of the retail dealer's total gasoline gallonage.

"Biofuel threshold percentage" is dependent on the aggregate number of gallons of motor fuel sold by a retail dealer during a determination period, as set forth below:

Determination Period	More that 200,000 Gallons Sold by Retail Dealer	200,000 Gallons or Less Sold by Retail Dealer
2009	10%	6%
2010	11%	6%
2011	12%	10%
2012	13%	11%
2013	14%	12%
2014	15%	13%

2015	17%	14%
2016	19%	15%
2017	21%	17%
2018	23%	19%
2019	25%	21%
2020	25%	25%

"Biofuel threshold percentage disparity" means the positive percentage difference between the retail dealer's biofuel threshold percentage and the retail dealer's biofuel distribution percentage. For example, if a retail dealer that sells more than 200,000 gallons of motor fuel in 2009 has a biofuel distribution percentage of 8 percent, the biofuel threshold percentage disparity equals 2 percent (10% minus 2%).

"Determination period" means any 12-month period beginning on January 1 and ending on December 31.

"Ethanol gallonage" means the total number of gallons of ethanol which the retail dealer sells from motor fuel pumps during a determination period. For example, 10,000 gallons of ethanol blended gasoline formulated with a 10 percent by volume of ethanol sold during a determination period results in an ethanol gallonage of 1,000 (10,000 gallons times 10%).

"Gasoline gallonage" means the total number of gallons of gasoline sold by the retail dealer during a determination period.

42.39(2) *Calculation of tax credit.*

a. The tax credit is calculated by multiplying the retail dealer's total ethanol gallonage by the tax credit rate, which is adjusted based upon the retail dealer's biofuel threshold percentage disparity. The tax credit rate is set forth below:

Biofuel Threshold Percentage Disparity	Tax Credit Rate per Gallon 2009-2010	Tax Credit Rate per Gallon 2011	Tax Credit Rate per Gallon 2012-2020
0%	6.5 cents	8 cents	8 cents
0.01% to 2.00%	4.5 cents	6 cents	6 cents
2.01% to 4.00%	2.5 cents	2.5 cents	4 cents
4.01% or more	0 cents	0 cents	0 cents

b. For use in calculating a retail dealer's total ethanol gallonage, the department is required to establish a schedule regarding the average amount of ethanol contained in E-85 gasoline.

c. A taxpayer may claim the ethanol promotion tax credit even if the taxpayer also claims the E-85 gasoline promotion tax credit provided in rule 701—42.33(422) or the E-15 plus gasoline promotion tax credit provided in rule 701—42.46(422) for the same tax year for the same ethanol gallons.

d. The tax credit must be calculated separately for each retail motor fuel site operated by the taxpayer for tax years beginning prior to January 1, 2011. The biofuel threshold percentage disparity of the taxpayer is computed on a statewide basis based on the total ethanol gallonage sold in Iowa. The taxpayer must determine the ethanol gallonage sold at each retail motor fuel site and multiply this ethanol gallonage by the applicable tax credit rate based on the biofuel threshold percentage disparity to calculate the ethanol promotion tax credit.

e. For tax years beginning on or after January 1, 2011, the taxpayer may elect to compute the biofuel threshold percentage disparity and the tax credit on either a site-by-site basis or on a companywide basis. The election made on the first return beginning on or after January 1, 2011, for either the site-by-site method or the companywide method is binding on the taxpayer for subsequent tax years unless the taxpayer petitions the department for a change in the method. Any petition for a change in the method should be made within a reasonable period of time prior to the due date of the return for which the change is requested. For example, if a change is requested for the tax return beginning January 1, 2012, the petition should be made by January 31, 2013, which is 90 days prior to the due date of the return.

The mere fact that a change in the method will result in a larger tax credit for subsequent years is not, of itself, sufficient grounds for changing the method for computing the credit. An example of a case for which the department may grant a change in the method is if the taxpayer has a significant change in the type of fuel sold at the taxpayer's retail sites in Iowa. For example, if a retail dealer opted to start selling E-85 gasoline at all the taxpayer's retail sites in Iowa for a subsequent tax year, the department may grant a change in the method.

If a taxpayer chooses the site-by-site method to compute the biofuel threshold percentage disparity, the gallons sold at all sites in Iowa must be considered in determining if the biofuel threshold percentage as defined in subrule 42.39(1) is based on more than 200,000 gallons or on 200,000 gallons or less. For example, if a taxpayer operates three motor fuel sites in Iowa and each site sells 80,000 gallons of motor fuel during 2011, the biofuel threshold percentage of 12 percent must be used for each retail site if the tax credit is computed on a site-by-site basis, even though each retail site sold less than 200,000 gallons of motor fuel.

f. Any tax credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming a refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

42.39(3) *Fiscal year filers.* For taxpayers whose tax year is not on a calendar-year basis, the taxpayer may compute the ethanol promotion tax credit on the total ethanol gallonage sold during the year using the designated tax credit rates as shown in subrule 42.39(2), paragraph *"a."* Because the tax credit is repealed on January 1, 2021, a taxpayer whose tax year ends prior to December 31, 2020, may continue to claim the tax credit in the following tax year for the total ethanol gallonage sold through December 31, 2020. A taxpayer whose tax year is not on a calendar-year basis and that did not claim the ethanol promotion tax credit on the previous return may claim the tax credit for the current tax year for the period beginning on January 1 of the previous tax year until the last day of the previous tax year.

42.39(4) *Allocation of tax credit to owners of a business entity.* If a taxpayer claiming the ethanol promotion tax credit is a partnership, limited liability company, S corporation, estate, or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by the individual must be based on the individual's pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, estate, or trust.

42.39(5) *Examples.* The following noninclusive examples illustrate how this rule applies:

EXAMPLE 1. A taxpayer that is a retail dealer of gasoline operates only one motor fuel site in Iowa. The number of gallons of gasoline sold at this site in 2009 equals 100,000 gallons. This consisted of 5,000 gallons of E-85 gasoline, 80,000 gallons of E-10 (10% ethanol blended gasoline) and 15,000 gallons not containing ethanol. The average ethanol content of E-85 gasoline is assumed to be 79%. The taxpayer also sold at this site during 2009 15,000 gallons of diesel fuel, of which 5,000 gallons was B-2 (2% biodiesel). The ethanol gallonage is 11,950 (5,000 E-85 gallons times 79% equals 3,950; 80,000 E-10 gallons times 10% equals 8,000; and thus 3,950 plus 8,000 equals 11,950). The biodiesel gallonage sold is 100, or 5,000 times 2%. The sum of 11,950 and 100, or 12,050, is divided by the total gasoline gallonage of 100,000 to arrive at a biofuel distribution percentage of 12.05%. Since this percentage exceeds the biofuel threshold percentage of 6% for a retail dealer selling 200,000 gallons or less, the biofuel threshold disparity percentage is 0%. This calculation results in an ethanol promotion tax credit of 6.5 cents times 11,950, or $776.75.

In addition, the taxpayer is entitled to claim the E-85 gasoline promotion tax credit equal to 20 cents multiplied by 5,000 gallons, or $1,000.

EXAMPLE 2. A taxpayer that is a retail dealer of gasoline operates only one motor fuel site in Iowa. The number of gallons of gasoline sold at this site in 2010 equals 300,000 gallons which consisted of 10,000 gallons of E-85 gasoline, 230,000 gallons of E-10 (10% ethanol blended gasoline) and 60,000 gallons not containing ethanol. The average ethanol content of E-85 gasoline is assumed to be 79%. The taxpayer also sold 60,000 gallons of diesel fuel at this site during 2010, of which 25,000 gallons was B-2 (2% biodiesel). The ethanol gallonage is 30,900 (10,000 E-85 gallons times 79% equals 7,900; 230,000 E-10 gallons times 10% equals 23,000; and thus 7,900 plus 23,000 equals 30,900). The biodiesel gallonage sold is 500, or 25,000 times 2%. The sum of 30,900 and 500, or 31,400, is divided by the total gasoline gallonage of 300,000 to arrive at a biofuel distribution percentage of 10.47%. Since this is less

than the biofuel threshold percentage of 11% for a retail dealer selling more than 200,000 gallons, the biofuel threshold disparity percentage is .53%. This calculation results in an ethanol promotion tax credit of 4.5 cents times 30,900, or $1,390.50.

In addition, the taxpayer is entitled to claim the E-85 gasoline promotion tax credit equal to 20 cents multiplied by 10,000 gallons, or $2,000.

EXAMPLE 3. A taxpayer that is a retail dealer of gasoline operates three motor fuel sites in Iowa during 2009, and each site sold 80,000 gallons of gasoline. Sites A and B each sold 70,000 gallons of E-10 (10% ethanol blended gasoline) and 10,000 gallons not containing ethanol. Site C sold 60,000 gallons of E-10, 10,000 gallons of E-85, and 10,000 gallons not containing ethanol. The average ethanol content of E-85 gasoline is assumed to be 79%. The retail dealer did not sell any diesel fuel at any of the motor fuel sites. The ethanol gallonage is 27,900, as shown below:

Site A – 70,000 times 10% equals	7,000
Site B – 70,000 times 10% equals	7,000
Site C – 60,000 times 10% equals	6,000
Site C – 10,000 times 79% equals	7,900
Total	27,900

The ethanol gallonage of 27,900 is divided by the gasoline gallonage of 240,000 to arrive at a biofuel distribution percentage of 11.63%. Since this exceeds the biofuel threshold percentage of 10% for a retail dealer selling more than 200,000 gallons, the biofuel threshold disparity percentage is 0%. The credit is computed separately for each motor fuel site, and the ethanol promotion credit equals $1,813.50, as shown below:

Site A – 7,000 times 6.5 cents equals	$455.00
Site B – 7,000 times 6.5 cents equals	$455.00
Site C – 13,900 times 6.5 cents equals	$903.50
Total	$1,813.50

Since the biofuel distribution percentage and the biofuel threshold percentage disparity are computed on a statewide basis for all gallons sold in Iowa, the 6.5 cent tax credit rate is applied to the total ethanol gallonage, even if Sites A and B did not meet the biofuel threshold percentage of 10% for 2009.

In addition, the taxpayer is entitled to claim the E-85 gasoline promotion tax credit equal to 20 cents multiplied by 10,000 gallons, or $2,000.

EXAMPLE 4. A taxpayer that is a retail dealer of gasoline has a fiscal year ending March 31, 2011, and operates one motor fuel site in Iowa. The taxpayer sold more than 200,000 gallons of gasoline during the 2010 calendar year and expects to sell more than 200,000 gallons of gasoline during the 2011 calendar year. The ethanol gallonage is 30,000 for the period from April 1, 2010, through December 31, 2010, and the ethanol gallonage is 8,000 for the period from January 1, 2011, through March 31, 2011. The biofuel distribution percentage is 11.5% for the period from April 1, 2010, through December 31, 2010, and the biofuel distribution percentage is 11.8% for the period from January 1, 2011, through March 31, 2011. This results in a biofuel threshold percentage disparity of 0% (11.0 minus 11.5) for the period from April 1, 2010, through December 31, 2010, and a biofuel threshold percentage disparity of .2% (12.0 minus 11.8) for the period from January 1, 2011, through March 31, 2011. The taxpayer is entitled to an ethanol promotion tax credit of $2,310 for the fiscal year ending March 31, 2011, as shown below:

30,000 times 6.5 cents equals	$1,950
8,000 times 4.5 cents equals	360
Total	$2,310

EXAMPLE 5. A taxpayer that is a retail dealer of gasoline has a fiscal year ending April 30, 2009, and operates one motor fuel site in Iowa. The taxpayer expects to sell more than 200,000 gallons of gasoline

during the 2009 calendar year. The ethanol gallonage is 50,000 gallons for the period from January 1, 2009, through April 30, 2009. The biofuel distribution percentage is 7.7% for the period from January 1, 2009, through April 30, 2009, which results in a biofuel threshold percentage disparity of 2.3% (10.0 minus 7.7). The taxpayer is entitled to claim an ethanol promotion tax credit of $1,250 (50,000 gallons times 2.5 cents) on the taxpayer's Iowa income tax return for the period ending April 30, 2009.

In lieu of claiming the credit on the return for the period ending April 30, 2009, the taxpayer may claim the ethanol promotion tax credit on the tax return for the period ending April 30, 2010, including the ethanol gallonage for the period from January 1, 2009, through April 30, 2010. In this case, the taxpayer will compute the biofuel distribution percentage for the period from January 1, 2009, through December 31, 2009, to determine the proper tax credit rate to be applied to the ethanol gallonage for the period from January 1, 2009, through December 31, 2009.

EXAMPLE 6. Assume the same facts as Example 3, except that the gallons were sold in 2011. The taxpayer chose the companywide method to compute the biofuel threshold percentage disparity and the tax credit. The biofuel distribution percentage is 11.63%, and since the biofuel threshold percentage is 12% for retailers selling more than 200,000 gallons of motor fuel, the biofuel threshold percentage disparity is 0.37%. This results in an ethanol promotion tax credit on a companywide basis of 6 cents multiplied by the ethanol gallonage of 27,900 or $1,674.

EXAMPLE 7. Assume the same facts as Example 3, except that the gallons were sold in 2011. The taxpayer chose the site-by-site method to compute the biofuel threshold percentage disparity and the tax credit. The biofuel threshold percentage is still 12% since the retailer sold more than 200,000 gallons of motor fuel at all sites in Iowa. The biofuel distribution percentage for Site A and Site B is 7,000 divided by 80,000, or 8.75%. The biofuel threshold percentage disparity for Site A and Site B is 3.25%, or 12% less than 8.75%. The biofuel distribution percentage for Site C is 13,900 divided by 80,000, or 17.38%. The biofuel threshold percentage disparity for Site C is 0% since the biofuel distribution percentage exceeds the biofuel threshold percentage. This results in an ethanol promotion tax credit on a site-by-site basis of $1,462, as shown below:

Site A – 7,000 times 2.5 cents equals	$175
Site B – 7,000 times 2.5 cents equals	$175
Site C – 13,900 times 8 cents equals	$1,112
Total	$1,462

This rule is intended to implement Iowa Code section 422.11N as amended by 2011 Iowa Acts, Senate File 531.
[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9821B**, IAB 11/2/11, effective 12/7/11]

701—42.40(422) Charitable conservation contribution tax credit. Effective for tax years beginning on or after January 1, 2008, a charitable conservation contribution tax credit is available for individual income tax which is equal to 50 percent of the fair market value of a qualified real property interest located in Iowa that is conveyed as an unconditional charitable donation in perpetuity by a taxpayer to a qualified organization exclusively for conservation purposes.

42.40(1) *Definitions.* The following definitions are applicable to this rule:

"Conservation purpose" means the same as defined in Section 170(h)(4) of the Internal Revenue Code, with the exception that a conveyance of land for open space for the purpose of fulfilling density requirements to obtain subdivision or building permits is not considered a conveyance for a conservation purpose.

"Qualified organization" means the same as defined in Section 170(h)(3) of the Internal Revenue Code.

"Qualified real property interest" means the same as defined in Section 170(h)(2) of the Internal Revenue Code. Conservation easements and bargain sales are examples of a qualified real property interest.

42.40(2) *Computation of the credit.* The credit equals 50 percent of the fair market value of the qualified real property interest. There are numerous federal revenue regulations, rulings, court cases and other provisions relating to the determination of the value of a qualified real property interest, and these are equally applicable in determining the amount of the charitable conservation contribution tax credit.

The maximum amount of the tax credit is $100,000. The amount of the contribution for which the tax credit is claimed shall not be claimed as an itemized deduction for charitable contributions for Iowa income tax purposes.

42.40(3) *Claiming the tax credit.* The tax credit is claimed on Form IA 148, Tax Credits Schedule. The taxpayer must include a copy of federal Form 8283, Noncash Charitable Contributions, which reflects the calculation of the fair market value of the real property interest, with the Iowa return for the year in which the contribution is made. If a qualified appraisal of the property or other relevant information is required to be included with federal Form 8283 for federal tax purposes, the appraisal and other relevant information must also be included with the Iowa return.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following 20 years or until used, whichever is the earlier.

If the taxpayer claiming the credit is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

42.40(4) *Examples.* The following noninclusive examples illustrate how this rule applies:

EXAMPLE 1: A taxpayer conveys a real property interest with a fair market value of $150,000 to a qualified organization during 2008. The tax credit is equal to $75,000, or 50 percent of the $150,000 fair market value of the real property. The taxpayer cannot claim the $150,000 as an itemized deduction for charitable contributions on the Iowa individual income tax return for 2008.

EXAMPLE 2: A taxpayer conveys a real property interest with a fair market value of $500,000 to a qualified organization during 2009. The tax credit is limited to $100,000, which equates to $200,000 of the contribution being eligible for the tax credit. The remaining amount of $300,000 ($500,000 less $200,000) can be claimed as an itemized deduction for charitable contributions on the Iowa individual income tax return for 2009.

This rule is intended to implement Iowa Code section 422.11W.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 1744C**, IAB 11/26/14, effective 12/31/14]

701—42.41(15,422) Redevelopment tax credit. The economic development authority is authorized by the general assembly and the governor to oversee the implementation and administration of the redevelopment tax credit program. Effective for tax years beginning on or after July 1, 2009, a taxpayer whose project has been approved by the Iowa brownfield redevelopment advisory council and the economic development authority may claim a redevelopment tax credit once the taxpayer has been issued a tax credit certificate for the project by the economic development authority. The credit is based on the taxpayer's qualifying investment in a brownfield or grayfield site. The administrative rules for the economic development authority's administration of this program, including definitions of brownfield and grayfield sites, may be found in rules 261—65.11(15) and 261—65.12(15).

42.41(1) *Eligibility for the credit.* The economic development authority is responsible for developing a system for registration and authorization of projects receiving redevelopment tax credits. For more information, see Iowa Administrative Code 261—Chapter 65.

42.41(2) *Amount of the credit.*

a. Maximum credit total. For the fiscal year beginning July 1, 2009, the maximum amount of tax credits allowed is $1 million, and the amount of credit authorized for any one redevelopment project cannot exceed $100,000. For the fiscal year beginning July 1, 2011, the maximum amount of tax credit allowed cannot exceed $5 million, and the amount of credit authorized for any one redevelopment project cannot exceed $500,000. For the fiscal year beginning July 1, 2012, the maximum amount of tax credits allowed cannot exceed $10 million, and the amount of credit authorized for any one redevelopment project cannot exceed $1 million. For the fiscal year beginning July 1, 2013, and for each subsequent

fiscal year, the maximum amount of tax credits issued by the authority shall be an amount determined by the economic development authority board but not in excess of the amount established pursuant to Iowa Code section 15.119.

b. Maximum credit per project. The maximum amount of a tax credit for a qualifying investment in any one qualifying redevelopment project shall not exceed 10 percent of the maximum amount of tax credits available in any one fiscal year pursuant to paragraph 42.41(2)*"a."*

c. Percentage computation. The amount of the tax credit shall equal one of the following:

(1) Twelve percent of the taxpayer's qualifying investment in a grayfield site.

(2) Fifteen percent of the taxpayer's qualifying investment in a grayfield site if the qualifying redevelopment project meets the requirements of green development as defined in rule 261—65.2(15).

(3) Twenty-four percent of the taxpayer's qualifying investment in a brownfield site.

(4) Thirty percent of the taxpayer's qualifying investment in a brownfield site if the qualifying redevelopment project meets the requirements of green development as defined in rule 261—65.2(15).

42.41(3) *Claiming the credit.*

a. Certificate issuance. Upon completion of the project, the economic development authority will issue a tax credit certificate to the taxpayer. The tax credit certificate will include the taxpayer's name, address and federal identification number, the tax type for which the credit will be claimed, the amount of the credit, the tax year for which the credit may be claimed and the tax credit certificate number. In addition, the tax credit certificate will include a place for the name and tax identification number of a transferee and the amount of the tax credit being transferred, as provided in subrule 42.41(4). To claim the tax credit, the taxpayer must include the tax credit certificate with the tax return for the tax period set forth on the certificate.

b. Pro rata share. If a taxpayer claiming the tax credit is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

c. Carryforward. Except as provided in paragraph 42.41(3)*"d,"* any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is the earlier. The tax credit shall not be carried back to a tax year prior to the year in which the taxpayer redeems the credit.

d. Refundability. A tax credit in excess of the taxpayer's liability for the tax year is refundable if all of the conditions of economic development authority 261—paragraph 65.11(4)*"b"* are met.

42.41(4) *Transfer of the credit.* The redevelopment tax credit can be transferred to any person or entity. However, a certificate indicating that the credit is refundable is only transferrable to the extent permitted by economic development authority 261—paragraph 65.11(4)*"b."*

a. Submission of transferred tax credit certificate to the department—information required. Within 90 days of transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the department of revenue, along with a statement which contains the transferee's name, address and tax identification number and the amount of the tax credit being transferred, the amount of all consideration provided in exchange for the tax credit, and the names of recipients of any consideration provided in exchange for the tax credit. If a payment of money was any part of the consideration provided in exchange for the tax credit, the transferee shall list the amount of the payment of money in its statement to the department of revenue. If any part of the consideration provided in exchange for the tax credit included nonmonetary consideration, including but not limited to any promise, representation, performance, discharge of debt or nonmonetary rights or property, the transferee shall describe the nature of nonmonetary consideration and disclose any value the transferor and transferee assigned to the nonmonetary consideration. The transferee must indicate on its statement to the department of revenue if no consideration was provided in exchange for the tax credit. If the transferee is a partnership, limited liability company, S corporation, or estate or trust claiming the credit for individual or corporation income tax, the transferee shall provide a list of the partners, members, shareholders or beneficiaries and information on how the redevelopment tax credit should be divided

among the partners, members, shareholders or beneficiaries. The transferee shall also provide the tax identification numbers and addresses of the partners, members, shareholders or beneficiaries.

b. Issuance of replacement certificate by the department. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee, the department of revenue will issue a replacement tax credit certificate to the transferee.

c. Claiming the transferred tax credit. The replacement tax credit certificate must contain the same information as that on the original tax credit certificate and must have the same effective taxable year as the original tax credit certificate. The replacement tax credit certificate may reflect a different tax type than the original tax credit certificate. The transferee may use the amount of the tax credit for any tax year for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit certificate shall not be included in Iowa taxable income for individual income tax, corporation income tax, or franchise tax purposes. Any consideration paid for the transfer of the tax credit certificate shall not be deducted from Iowa taxable income for individual income tax, corporation income tax, or franchise tax purposes.

42.41(5) *Basis reduction of the redevelopment property.* The increase in the basis of the redevelopment property that would otherwise result from the qualified redevelopment costs shall be reduced by the amount of the redevelopment tax credit. For example, if a qualifying investment in a grayfield site totaled $100,000 for which a $12,000 redevelopment tax credit was issued, the increase in the basis of the property would total $88,000 for Iowa tax purposes ($100,000 less $12,000).

This rule is intended to implement Iowa Code sections 15.293A, 422.11V and 15.119.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9876B**, IAB 11/30/11, effective 1/4/12; **ARC 1102C**, IAB 10/16/13, effective 11/20/13; **ARC 1949C**, IAB 4/1/15, effective 5/6/15]

701—42.42(15) High quality jobs program. Effective for tax periods beginning on or after July 1, 2009, a business which qualifies under the high quality jobs program is eligible to receive tax credits. The high quality jobs program replaces the high quality job creation program. An eligible business under the high quality jobs program must be approved by the Iowa department of economic development and meet the qualifications of Iowa Code section 15.329. The tax credits available under the high quality jobs program are based upon the number of jobs created or retained that pay a qualifying wage threshold and the amount of qualifying investment. The administrative rules for the high quality jobs program for the Iowa department of economic development may be found at 261—Chapter 68.

42.42(1) *Research activities credit.* An eligible business approved under the high quality jobs program is eligible for an additional research activities credit as described in 701—subrule 52.7(4) for awards issued by the Iowa department of economic development prior to July 1, 2010. The eligible business is eligible for the research activities credit as described in 701—subrule 52.7(6) for awards issued by the Iowa department of economic development on or after July 1, 2010.

Research activities allowable for the Iowa research activities credit include expenses related to the development and deployment of innovative renewable energy generation components manufactured or assembled in Iowa; such expenses related to the development and deployment of innovative renewable energy generation components are not eligible for the federal credit for increasing research activities. For purposes of this subrule, innovative renewable energy generation components do not include components with more than 200 megawatts in installed effective nameplate generating capacity. The research activities credit related to renewable energy generation components under the high quality jobs program and the enterprise zone program shall not exceed $2 million for the fiscal year ending June 30, 2010, and $1 million for the fiscal year ending June 30, 2011.

These expenses related to the development and deployment of innovative renewable energy generation components are applicable only to the additional research activities credit set forth in this subrule and in 701—subrule 52.7(5) for businesses in enterprise zones, and are not applicable to the research activities credit set forth in subrule 42.11(3), paragraphs *"a"* and *"b."*

42.42(2) *Investment tax credit.* An eligible business can claim an investment tax credit equal to a percentage of the new investment directly related to new jobs created or retained by the location or

expansion of an eligible business. The percentage is equal to the amount provided in Iowa department of economic development 261—subrule 68.4(7).

The determination of the new investment eligible for the investment tax credit, the eligibility of a refundable investment tax credit for value-added agricultural product or biotechnology-related projects and the repayment of investment tax credits for the high quality jobs program is the same as set forth in subrule 42.29(2) for the high quality job creation program.

42.42(3) *Repayment of benefits.* If an eligible business fails to maintain the requirements of the high quality jobs program, the taxpayer may be required to repay all or a portion of the tax incentives taken on Iowa returns. Irrespective of the fact that the statute of limitations to assess the taxpayer for repayment of the tax credits may have expired, the department may proceed to collect the tax incentives forfeited by failure of the eligible business to maintain the requirements of the high quality jobs program because the repayment is a recovery of an incentive, rather than an adjustment to the taxpayer's tax liability. Details on the calculation of the repayment can be found in 261—subrule 187.5(4) of the administrative rules of the economic development authority. If the business is a partnership, limited liability company, S corporation, estate or trust where the income of the taxpayer is taxed to the individual owner(s) of the business, the department may proceed to collect the tax incentives against the partners, members, shareholders or beneficiaries to whom the tax incentives were passed through. See Decision of the Administrative Law Judge in *Damien & Colette Trebilcock, et al.,* Docket No. 11DORF 042-044, June 11, 2012.

This rule is intended to implement Iowa Code chapter 15.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10; **ARC 1744C**, IAB 11/26/14, effective 12/31/14]

701—42.43(16,422) Disaster recovery housing project tax credit. For tax years beginning on or after January 1, 2011, but before January 1, 2015, a disaster recovery housing project tax credit is available for individual income tax. The credit is equal to 75 percent of the taxpayer's qualifying investment in a disaster recovery housing project, and is administered by the Iowa finance authority. Qualifying investments are costs incurred on or after May 12, 2009, and prior to July 1, 2010, related to a disaster recovery housing project. Eligible properties must have applied for and received an allocation of federal low-income housing tax credits under Section 42 of the Internal Revenue Code to be eligible for the tax credit. The tax credit is repealed effective January 1, 2015.

42.43(1) *Issuance of tax credit certificates.* Upon completion of the project and verification of the amount of investment made in the disaster recovery housing project, the Iowa finance authority will issue a tax credit certificate to the taxpayer. The tax credit certificate shall include the taxpayer's name, address, tax identification number, amount of credit, and the tax year for which the credit may be claimed. The tax credit certificates will be issued on a first-come, first-served basis. The tax credit cannot be transferred to any person or entity.

42.43(2) *Limitation of tax credits.* The tax credit shall not exceed 75 percent of the taxpayer's qualifying investment in a disaster recovery housing project. The maximum amount of tax credits issued by the Iowa finance authority shall not exceed $3 million in each of the five consecutive years beginning in the 2011 calendar year. A tax credit certificate shall be issued by the Iowa finance authority for each year that the credit can be claimed.

42.43(3) *Claiming the tax credit.* The amount of the tax credit earned by the taxpayer will be divided by five and an amount equal thereto will be claimed on the Iowa individual income tax return commencing with the tax year beginning on or after January 1, 2011. A taxpayer is not entitled to a refund of the excess tax for any tax credit in excess of the tax liability, and also is not entitled to carry forward any excess credit to a subsequent tax year.

If the taxpayer is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

The increase in the basis of the property that would otherwise result from the disaster recovery housing investment shall be reduced by the amount of the tax credit allowed.

EXAMPLE: An individual whose tax year ends on December 31 incurs $100,000 of costs related to an eligible disaster recovery housing project. The taxpayer receives a tax credit of $75,000, and $15,000 of credit can be claimed on each Iowa individual income tax return for the periods ending December 31, 2011, through December 31, 2015. If the tax liability for the individual for the period ending December 31, 2011, is $10,000, the credit is limited to $10,000, and the remaining $5,000 credit cannot be used. If the tax liability for the individual for the period ending December 31, 2012, is $25,000, the credit is limited to $15,000, and the remaining $5,000 credit from 2011 cannot be used to reduce the tax for 2012.

42.43(4) *Potential recapture of tax credits.* If the taxpayer fails to comply with the eligibility requirements of the project or violates local zoning and construction ordinances, the Iowa finance authority can void the tax credit and the department of revenue shall seek recovery of the value of any tax credit claimed on an individual income tax return.

This rule is intended to implement Iowa Code sections 16.211, 16.212 and 422.11X as amended by 2014 Iowa Acts, Senate File 2328.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 1665C**, IAB 10/15/14, effective 11/19/14]

701—42.44(422) Deduction of credits. The credits against computed tax set forth in Iowa Code sections 422.5, 422.8, 422.10 through 422.12C, and 422.110 shall be claimed in the following sequence:

1. Personal exemption credit.
2. Tuition and textbook credit.
3. Volunteer fire fighter, volunteer emergency medical services personnel and reserve peace officer tax credit.
4. Nonresident and part-year resident credit.
5. Franchise tax credit.
6. S corporation apportionment credit.
7. School tuition organization tax credit.
8. Venture capital tax credits (excluding redeemed Iowa fund of funds tax credit).
9. Endow Iowa tax credit.
10. Film qualified expenditure tax credit.
11. Film investment tax credit.
12. Redevelopment tax credit.
13. From farm to food donation tax credit.
14. Workforce housing tax credit.
15. Investment tax credit.
16. Wind energy production tax credit.
17. Renewable energy tax credit.
18. Redeemed Iowa fund of funds tax credit.
19. New jobs tax credit.
20. Economic development region revolving fund tax credit.
21. Agricultural assets transfer tax credit.
22. Custom farming contract tax credit.
23. Geothermal heat pump tax credit.
24. Solar energy system tax credit.
25. Charitable conservation contribution tax credit.
26. Alternative minimum tax credit.
27. Historic preservation and cultural and entertainment district tax credit.
28. Ethanol promotion tax credit.
29. Research activities credit.
30. Out-of-state tax credit.
31. Child and dependent care tax credit or early childhood development tax credit.
32. Motor fuel tax credit.

33. Claim of right credit (if elected in accordance with rule 701—38.18(422)).
34. Wage-benefits tax credit.
35. Adoption tax credit.
36. E-85 gasoline promotion tax credit.
37. Biodiesel blended fuel tax credit.
38. E-15 plus gasoline promotion tax credit.
39. Earned income tax credit.
40. Iowa taxpayers trust fund tax credit.
41. Estimated payments, payment with vouchers, and withholding tax.

This rule is intended to implement Iowa Code sections 422.5, 422.8, 422.10, 422.11, 422.11A, 422.11B, 422.11D, 422.11E, 422.11F, 422.11H, 422.11I, 422.11J, 422.11L, 422.11M, 422.11N, 422.11O, 422.11P, 422.11Q, 422.11R, 422.11S, 422.11V, 422.11W, 422.11Y, 422.11Z, 422.12, 422.12B, 422.12C and 422.110 and 2014 Iowa Acts, House Files 2448 and 2468.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9876B**, IAB 11/30/11, effective 1/4/12; **ARC 0398C**, IAB 10/17/12, effective 11/21/12; **ARC 1303C**, IAB 2/5/14, effective 3/12/14; **ARC 1744C**, IAB 11/26/14, effective 12/31/14]

701—42.45(15) Aggregate tax credit limit for certain economic development programs. Effective for the fiscal year beginning July 1, 2009, awards made under certain economic development programs cannot exceed $185 million during a fiscal year. Effective for fiscal years beginning on or after July 1, 2010, but beginning before July 1, 2012, awards made under these economic development programs cannot exceed $120 million during a fiscal year. Effective for fiscal years beginning on or after July 1, 2012, awards made under these economic development programs cannot exceed $170 million. For fiscal years beginning on or after July 1, 2010, but beginning before July 1, 2014, these programs include the assistive device tax credit program, the enterprise zone program, the housing enterprise zone program, the high quality jobs program, the redevelopment tax credit program, tax credits for investments in qualifying businesses and community-based seed capital funds, and the innovation fund tax credit program. For fiscal years beginning on or after July 1, 2014, these programs include the assistive device tax credit program, the workforce housing tax incentives program, the high quality jobs program, the redevelopment tax credit program, tax credits for investments in qualifying businesses and community-based seed capital funds, and the innovation fund tax credit program. The administrative rules for the aggregate tax credit limit for the economic development authority may be found at 261—Chapter 76.

This rule is intended to implement Iowa Code section 15.119 as amended by 2014 Iowa Acts, House File 2448.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10; **ARC 1102C**, IAB 10/16/13, effective 11/20/13; **ARC 1744C**, IAB 11/26/14, effective 12/31/14]

701—42.46(422) E-15 plus gasoline promotion tax credit. Effective for eligible gallons sold on or after July 1, 2011, a retail dealer of gasoline may claim an E-15 plus gasoline promotion tax credit. "E-15 plus gasoline" means ethanol blended gasoline formulated with a minimum percentage of between 15 percent and 69 percent of volume of ethanol, if the formulation meets the standards provided in Iowa Code section 214A.2. For purposes of this rule, tank wagon sales are considered retail sales. The credit is calculated on Form IA138. The tax credit is calculated by multiplying the total number of E-15 plus gallons sold by the retail dealer during the tax year by the following designated rates:

Gallons sold from July 1, 2011, through December 31, 2013	3 cents
Gallons sold from January 1 through May 31 and from September 16 through December 31 for the 2014-2017 calendar years	3 cents
Gallons sold from June 1 through September 15 for the 2014-2017 calendar years	10 cents

A taxpayer may claim the E-15 plus gasoline promotion tax credit even if the taxpayer also claims the ethanol promotion tax credit provided in rule 701—42.39(422) for gallons sold for the same tax year for the same ethanol gallons.

Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

42.46(1) *Fiscal year filers.* For taxpayers whose tax year is not on a calendar-year basis, the taxpayer may compute the tax credit on the gallons of E-15 plus gasoline sold during the year using the designated rates as shown above. Because the tax credit is repealed on January 1, 2018, a taxpayer whose tax year ends prior to December 31, 2017, may continue to claim the tax credit in the following tax year for any E-15 plus gallons sold through December 31, 2017. For a retail dealer whose tax year is not on a calendar-year basis and who did not claim the E-15 plus credit on the previous return, the dealer may claim the credit for the current tax year for gallons sold for the period beginning on July 1 of the previous tax year until the last day of the previous tax year. However, for taxpayers whose fiscal year ends before December 31, 2011, the dealer must claim the credit for the current tax year for gallons sold for the period beginning on July 1 of the previous tax year until the last day of the previous tax year.

EXAMPLE 1: A taxpayer who is a retail dealer of gasoline has a fiscal year ending October 31, 2011. The taxpayer sold 2,000 gallons of E-15 plus gasoline for the period from July 1, 2011, through October 31, 2011, and sold 7,000 gallons of E-15 plus gasoline for the period from November 1, 2011, through October 31, 2012. The taxpayer is entitled to a total E-15 plus gasoline promotion tax credit of $270 for the fiscal year ending October 31, 2012, which consists of a $60 credit (2,000 gallons multiplied by 3 cents) for the period from July 1, 2011, through October 31, 2011, and a credit of $210 (7,000 gallons multiplied by 3 cents) for the period from November 1, 2011, through October 31, 2012.

EXAMPLE 2: A taxpayer who is a retail dealer of gasoline has a fiscal year ending April 30, 2012. The taxpayer sold 4,000 gallons of E-15 plus gasoline between July 1, 2011, and April 30, 2012. The taxpayer sold 9,000 gallons of E-15 plus gasoline between May 1, 2012, and April 30, 2013. The taxpayer is entitled to claim an E-15 plus gasoline promotion tax credit of $120 (4,000 gallons times 3 cents) for the fiscal year ending April 30, 2012. In lieu of claiming the credit on the return for the period ending April 30, 2012, the taxpayer can claim the E-15 plus gasoline promotion tax credit on the tax return for the period ending April 30, 2013, for all E-15 plus gasoline gallons sold for the period from July 1, 2011, through April 30, 2013.

EXAMPLE 3: A taxpayer who is a retail dealer of gasoline has a fiscal year ending February 28, 2018. The taxpayer sold 20,000 gallons of E-15 plus gasoline for the period from March 1, 2017, through February 28, 2018, of which 16,000 gallons were sold between March 1, 2017, and December 31, 2017. Six thousand of these 16,000 gallons were sold between June 1, 2017, and September 15, 2017. The taxpayer is entitled to claim an E-15 plus gasoline promotion tax credit of $900 (10,000 gallons times 3 cents plus 6,000 gallons times 10 cents) on the taxpayer's Iowa income tax return for the period ending February 28, 2018.

42.46(2) *Allocation of credit to owners of a business entity.* If a taxpayer claiming the E-15 plus gasoline promotion tax credit is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement Iowa Code section 422.11Y as amended by 2014 Iowa Acts, Senate File 2344.

[**ARC 9821B**, IAB 11/2/11, effective 12/7/11; **ARC 1665C**, IAB 10/15/14, effective 11/19/14]

701—42.47(422) Geothermal tax credits. There are two distinct Iowa geothermal heat pump tax credits. Each Iowa credit is described in detail below. The Iowa credit described in subrule 42.47(1) is only available for years in which the federal credit provided in Section 25D(a)(5) of the Internal Revenue Code is also available. The Iowa credit described in subrule 42.47(2) is only available for years in which the federal credit provided in Section 25D(a)(5) of the Internal Revenue Code is not available.

42.47(1) *Geothermal heat pump tax credit for years in which the federal credit is available.*

a. Availability of the credit. For tax years beginning on or after January 1, 2012, in which the federal residential energy efficient property tax credit for geothermal heat pumps provided in Section 25D(a)(5) of the Internal Revenue Code is available, an Iowa geothermal heat pump tax credit, as described in this subrule, is also available for residential property located in Iowa.

b. Eligibility for the credit. To be eligible for the credit described in this subrule, all of the following requirements must be met:

(1) The geothermal heat pump must be eligible for the federal residential energy efficient property tax credit provided in Section 25D(a)(5) of the Internal Revenue Code.

(2) The taxpayer must claim the federal residential energy efficient property tax credit.

(3) The geothermal heat pump must be installed on or after January 1, 2012, to qualify for the Iowa credit. If the taxpayer installed a geothermal heat pump and initially reported the federal tax credit for a tax year beginning prior to January 1, 2012, no Iowa credit will be allowed.

EXAMPLE: A taxpayer reported a $6,000 geothermal tax credit on the 2011 federal return due to an installation that was completed in 2011. The taxpayer applied $2,000 of the credit on the taxpayer's 2011 federal return since the federal tax liability was $2,000. The remaining $4,000 of federal credit was applied on the 2012 federal return. No credit will be allowed on the 2012 Iowa return since the installation was completed before January 1, 2012.

c. Calculation of the credit. The credit described in this subrule is equal to 20 percent of the federal residential energy efficient property tax credit allowed for geothermal heat pumps provided in Section 25D(a)(5) of the Internal Revenue Code. As of the publication date of the Notice proposing to amend these rules, October 12, 2016, the federal residential energy efficient tax credit for geothermal heat pumps is allowed for installations that are completed on or before December 31, 2016. Therefore, the corresponding Iowa tax credit will be available for the 2012 to 2016 tax years. If the federal residential energy efficient property tax credit for geothermal heat pumps is extended into additional tax years, absent action by the Iowa legislature to repeal the Iowa credit, the Iowa credit described in this subrule will continue to be available for each year in which the federal residential energy efficient property tax credit for geothermal heat pumps is available.

d. Claiming the tax credit. The geothermal heat pump tax credit must be claimed on Form IA 148, Tax Credit Schedule. The taxpayer must include a valid copy of the taxpayer's federal Form 5695, Residential Energy Credits, with the Iowa tax return for the tax year in which the geothermal heat pump was installed claiming the geothermal heat pump credit described in this subrule.

e. Refundability. Any credit in excess of the taxpayer's tax liability is nonrefundable.

f. Carryforward. Any tax credit in excess of the taxpayer's tax liability for the tax year may be credited to the taxpayer's tax liability for the following ten years or until depleted, whichever is earlier.

g. Transferability. The credit may not be transferred to any other person.

42.47(2) *Geothermal tax credit for years in which the federal credit is not available.*

a. Availability of the credit. For tax years beginning on or after January 1, 2017, in which the federal residential energy efficient tax credit for geothermal heat pumps is not available, an Iowa geothermal tax credit is available for certain geothermal heat pump property installed in this state.

b. Definitions.

"Qualified geothermal heat pump property" means any equipment that meets the requirements of the federal Energy Star Program in effect at the time that the expenditure for such equipment is made and uses the ground or groundwater as either:

1. A thermal energy source to heat the dwelling unit of the taxpayer, or
2. A thermal energy sink to cool the dwelling unit of the taxpayer.

"Qualified geothermal heat pump property expenditure" means an expenditure for qualified geothermal heat pump property installed on or in connection with a dwelling unit that is:

1. Located in Iowa, and
2. Used as a residence by the taxpayer.

c. Eligibility for the credit. To be eligible for the credit described in this subrule, the qualified expenditures must be incurred:

(1) To install qualified geothermal heat pump property at a location in Iowa that is used as a residence by the taxpayer, and

(2) During the tax year for which the credit is claimed. Qualified geothermal heat pump property expenditures are deemed to have been made on the date the installation is complete. In the case of new construction or reconstruction, the expenditures are deemed to have been made on the date the taxpayer first began to use the structure as the taxpayer's residence.

d. Calculation of the credit. The credit described in this subrule is equal to 10 percent of the qualified geothermal heat pump property expenditures made by the taxpayer during the tax year. This credit is not available during any year in which the federal credit may be claimed, and no expenditure used to calculate the federal residential energy efficient property tax credit may be used to calculate the amount of the Iowa geothermal tax credit described in this subrule. For information on an Iowa tax credit that is available for years in which the federal residential energy efficient property tax credit for geothermal heat pump property is also available, see subrule 42.47(1).

e. Multiple housing cooperatives and horizontal property regimes. In the case of a taxpayer whose dwelling unit is part of a multiple housing cooperative organized under Iowa Code chapter 499A or a horizontal property regime under Iowa Code chapter 499B, the taxpayer shall be treated as having made the taxpayer's proportionate share of any qualified geothermal heat pump property expenditures made by the cooperative or the regime.

f. Claiming the credit. The geothermal credit described in this subrule must be claimed on Form IA 148, Tax Credit Schedule, and included with the tax return for the tax year in which the expenditures are deemed to have been made. In order to claim this credit, a taxpayer must also complete the form provided by the department to substantiate eligibility for the tax credit claimed and include any other information the department may require.

g. Refundability. Any credit in excess of the taxpayer's tax liability is nonrefundable.

h. Carryforward. Any tax credit in excess of the taxpayer's tax liability for the tax year may be credited to the taxpayer's tax liability for the following ten years or until depleted, whichever is earlier.

i. Transferability. The credit may not be transferred to any other person.

This rule is intended to implement Iowa Code section 422.11I and 2016 Iowa Acts, House File 2468.
[**ARC 0361C**, IAB 10/3/12, effective 11/7/12; **ARC 1744C**, IAB 11/26/14, effective 12/31/14; **ARC 2833C**, IAB 12/7/16, effective 1/11/17]

701—42.48(422) Solar energy system tax credit. For tax years beginning on or after January 1, 2012, a solar energy system tax credit is available for both residential property and business property located in Iowa.

42.48(1) *Property eligible for the tax credit.* The following property located in Iowa is eligible for the tax credit:

a. Qualified solar water heating property described in Section 25D(d)(1) of the Internal Revenue Code.

b. Qualified solar energy electric property described in Section 25D(d)(2) of the Internal Revenue Code.

c. Equipment which uses solar energy to generate electricity, to heat or cool (or to provide hot water for use in) a structure, or to provide solar process heat (excepting property used to generate energy for the purposes of heating a swimming pool) and which is eligible for the federal energy credit as described in Section 48(a)(3)(A)(i) of the Internal Revenue Code.

d. Equipment which uses solar energy to illuminate the inside of a structure using fiber-optic distributed sunlight and which is eligible for the federal energy credit as described in Section 48(a)(3)(A)(ii) of the Internal Revenue Code.

42.48(2) *Calculation of credit for systems installed during tax years beginning on or after January 1, 2012, but before January 1, 2014.* The credit is equal to the sum of the following federal tax credits:

a. Fifty percent of the federal residential energy property credit provided in Section 25D(a)(1) of the Internal Revenue Code.

b. Fifty percent of the federal residential energy property credit provided in Section 25D(a)(2) of the Internal Revenue Code.

c. Fifty percent of the federal energy credit provided in Section 48(a)(2)(A)(i)(II) of the Internal Revenue Code.

d. Fifty percent of the federal energy credit provided in Section 48(a)(2)(A)(i)(III) of the Internal Revenue Code.

The amount of tax credit claimed by a taxpayer related to paragraphs 42.48(2)*"a"* and *"b"* cannot exceed $3,000 for a tax year. The amount of tax credit claimed by a taxpayer related to paragraphs 42.48(2)*"c"* and *"d"* cannot exceed $15,000 for a tax year.

The federal residential energy efficient tax credits are allowed for installations that are completed and the federal energy tax credits for solar energy systems are allowed for installations that are placed in service before January 1, 2014. The solar energy system must be installed on or after January 1, 2012, to qualify for the Iowa credit. If the taxpayer installed a solar energy system and initially reported the federal tax credit for a tax year beginning prior to January 1, 2012, no Iowa credit will be allowed.

EXAMPLE: A taxpayer reported a $9,000 residential energy efficient tax credit on the 2011 federal return due to an installation of a solar energy system that was placed in service in 2011. The taxpayer applied $4,000 of the credit on the taxpayer's 2011 federal return since the federal tax liability was $4,000. The remaining $5,000 of federal credit was applied on the 2012 federal return. No credit will be allowed on the 2012 Iowa return since the installation was placed in service before January 1, 2012.

42.48(3) *Calculation of credit for systems installed during tax years beginning on or after January 1, 2014, but before January 1, 2017.* The credit is equal to the sum of the following federal tax credits:

a. Sixty percent of the federal residential energy property credit provided in Section 25D(a)(1) of the Internal Revenue Code.

b. Sixty percent of the federal residential energy property credit provided in Section 25D(a)(2) of the Internal Revenue Code.

c. Sixty percent of the federal energy credit provided in Section 48(a)(2)(A)(i)(II) of the Internal Revenue Code.

d. Sixty percent of the federal energy credit provided in Section 48(a)(2)(A)(i)(III) of the Internal Revenue Code.

The amount of tax credit claimed by a taxpayer related to paragraphs 42.48(3)*"a"* and *"b"* cannot exceed $5,000 for a tax year. The amount of tax credit claimed by a taxpayer related to paragraphs 42.48(3)*"c"* and *"d"* cannot exceed $20,000 for a tax year.

The federal residential energy efficient tax credits are allowed for installations that are completed on or before December 31, 2016, and the federal energy tax credits for solar energy systems are allowed for installations that are placed in service on or before December 31, 2016. Therefore, the Iowa tax credit is available for installations that are either completed or placed in service before January 1, 2017. If the federal residential energy property tax credits or the federal energy credits are extended to installations completed or placed in service on or after January 1, 2017, the Iowa tax credit will also be extended.

42.48(4) *Application for the tax credit.* No more than $1.5 million of tax credits for solar energy systems are allowed for tax years 2012 and 2013. The $1.5 million cap also includes the solar energy system tax credits provided in rule 701—52.44(422) for corporation income tax. No more than $4.5 million of tax credits for solar energy systems is allowed for each of the tax years 2014 to 2016. The $4.5 million cap does not include any dollars allocated to a previous tax year that roll over to the 2015 and 2016 tax years. The $4.5 million cap also includes the solar energy system tax credits provided in rule 701—52.44(422) for corporation income tax and in rule 701—58.22(422) for franchise tax. Awards of tax credits are made on a first-come, first-served basis. At least $1 million of the $4.5 million cap for the 2014 to 2016 tax years is reserved for residential installations. If the total amount of credits for residential installations for a tax year is less than $1 million, the remaining amount below $1 million will be allowed for nonresidential installations. If the $4.5 million cap for the 2014 and 2015 tax years is not reached, the remaining amount below $4.5 million will be allowed to be carried forward to the following tax year and shall not count toward the cap for that year.

a. A taxpayer may claim one tax credit for each separate and distinct solar installation. In order for an installation to be considered a separate and distinct solar installation, both of the following factors must be met:

(1) Each installation must be eligible for the federal residential energy property credit or the federal energy credit as provided in subrule 42.48(3).

(2) Each installation must have separate metering.

b. In order to request the tax credit, a taxpayer must complete an application for the solar energy tax credit for each separate and distinct installation. For installations completed on or after January 1, 2014, the application must be filed by May 1 following the year of installation of the solar energy system. The application must contain the following information:

(1) Name, address and federal identification number of the taxpayer.

(2) Date of installation of the solar energy system.

(3) The kilowatt capacity of the solar energy system.

(4) Copies of invoices or other documents showing the cost of the solar energy system.

(5) Amount of federal income tax credit for the solar energy system.

(6) Amount of Iowa tax credit requested.

(7) For nonresidential installations, a completion sheet from a local utility company verifying that the system has been placed in service. If a completion sheet is not available from the local utility company, a statement shall be provided that is similar to the one required to be attached to federal Form 3468 when claiming the federal energy credit and that specifies the date the system was placed in service.

c. If the application is approved, the department will send a letter to the taxpayer including the amount of the tax credit and providing a tax credit certificate number. The solar energy system tax credit will be claimed on Form IA 148, Tax Credits Schedule. Any tax credit in excess of the tax liability for the tax year may be credited to the tax liability for the following ten years or until used, whichever is the earlier. The taxpayer must include with any Iowa tax return claiming the solar energy system tax credit federal Form 5695, Residential Energy Credits, if claiming the residential energy credit or federal Form 3468, Investment Credit, if claiming the business energy credit.

If the department receives applications for tax credits in excess of the $1.5 million available for 2012 and 2013 and the $4.5 million available for 2014 to 2016, the applications will be prioritized by the date the department received the applications. If the number of applications exceeds the $1.5 or $4.5 million of tax credits available, the department shall establish a wait list for the next year's allocation of tax credits and the applications shall first be funded in the order listed on the wait list. However, if the $4.5 million cap of tax credit is reached for 2016, no applications in excess of the $4.5 million cap will be carried over to the next year, assuming there is no extension of the federal credit.

EXAMPLE: A taxpayer submitted an application for a $2,500 tax credit on December 1, 2012, for an installation that occurred in 2012. The application was denied on December 15, 2012, because the $1.5 million cap had already been reached for 2012. The taxpayer will be placed on a wait list and will receive priority for receiving the tax credit for the 2013 tax year. However, if the application was submitted on December 1, 2016, for an installation that occurred in 2016 and the $4.5 million cap had already been reached for 2016, no tax credit will be allowed for the 2017 tax year, assuming there is no extension of the federal credit.

d. A taxpayer who is eligible to receive a renewable energy tax credit provided in rule 701—42.28(422,476C) is not eligible for the solar energy system tax credit.

42.48(5) *Allocation of tax credit to owners of a business entity.* If the taxpayer claiming the tax credit based on a percentage of the federal energy credit under Section 48 of the Internal Revenue Code is a partnership, limited liability company, S corporation, estate or trust electing to have income taxed directly to the individual, the individual may claim the tax credit. The amount claimed by the individual shall be based upon the pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, estate or trust. The maximum amount of credit available to a partnership, limited liability

company, S corporation, estate or trust shall be limited to $15,000 for installations placed in service in tax years 2012 and 2013 and $20,000 for installations placed in service in tax years 2014 to 2016.

This rule is intended to implement Iowa Code section 422.11L as amended by 2014 Iowa Acts, Senate File 2340, and 2014 Iowa Acts, House File 2473, section 77.

[**ARC 0361C**, IAB 10/3/12, effective 11/7/12; **ARC 1303C**, IAB 2/5/14, effective 3/12/14; **ARC 1666C**, IAB 10/15/14, effective 11/19/14]

701—42.49(422) Volunteer fire fighter, volunteer emergency medical services personnel and reserve peace officer tax credit. Effective for tax years beginning on or after January 1, 2013, a tax credit is available for individual income tax for volunteer fire fighters and volunteer emergency medical services (EMS) personnel. Effective for tax years beginning on or after January 1, 2014, a tax credit is available for individual income tax for reserve peace officers.

42.49(1) *Definitions.* The following definitions are applicable to this rule:

"Emergency medical services personnel" or *"EMS personnel"* means an emergency medical care provider, as defined in Iowa Code section 147A.1, who is certified as a first responder in accordance with Iowa Code chapter 147A. For tax years beginning on or after January 1, 2014, "emergency medical services personnel" or "EMS personnel" also includes an individual who is a paid employee of an emergency medical services program and who is also a volunteer emergency medical services personnel in a city, county or area governed by an agreement pursuant to Iowa Code chapter 28E.

"Reserve peace officer" means a reserve peace officer as defined in Iowa Code section 80D.1A who has met the minimum state training standards established by the Iowa law enforcement academy in accordance with Iowa Code chapter 80D.

"Volunteer fire fighter" means a volunteer fire fighter, as defined in Iowa Code section 85.61, who has met the minimum training standards established by the fire service training bureau pursuant to Iowa Code chapter 100B. For tax years beginning on or after January 1, 2014, "volunteer fire fighter" means an individual who is an active member of an organized volunteer fire department in Iowa or is performing services as a volunteer fire fighter for a municipality, township or benefited fire district at the request of the chief or other person in command and who has met the minimum training standards established by the fire service training bureau pursuant to Iowa Code chapter 100B. For tax years beginning on or after January 1, 2014, a volunteer fire fighter also includes an individual who is a paid employee of a fire department and who is also a volunteer fire fighter in a city, county or area governed by an agreement pursuant to Iowa Code chapter 28E.

42.49(2) *Calculation of the credit.*

a. The credit is equal to $50 for the tax year beginning January 1, 2013, if the volunteer fire fighter or volunteer EMS personnel was a volunteer for the entire year. The credit is equal to $100 for tax years beginning on or after January 1, 2014, if the volunteer fire fighter, volunteer EMS personnel or reserve peace officer was a volunteer for the entire year.

b. If the individual was not a volunteer fire fighter or volunteer EMS personnel for the entire 2013 calendar year, the $50 credit is prorated based on the number of months the individual was a volunteer. Beginning in the 2014 calendar year, if the individual was not a volunteer fire fighter, volunteer EMS personnel or reserve peace officer for the entire year, the $100 credit is prorated based on the number of months the individual was a volunteer. If the individual was a volunteer during any part of a month, the individual will be considered a volunteer for the entire month. The amount of credit will be rounded to the nearest dollar.

EXAMPLE: An individual became a volunteer fire fighter on April 15, 2013, and remained a volunteer for the rest of calendar year 2013. The individual is considered a volunteer for nine months of 2013. The tax credit for 2013 is equal to $38 ($50 multiplied by 9/12 equals $37.50; rounding to the nearest dollar results in a $38 credit).

c. If an individual is both a volunteer fire fighter and a volunteer EMS personnel during the same month, a credit can be claimed for only one volunteer position for that month. Therefore, if an individual was both a volunteer fire fighter and volunteer EMS personnel for all of 2013, the tax credit will equal $50. In addition, beginning in calendar year 2014, if a reserve peace officer is also either a volunteer fire

fighter or a volunteer EMS personnel, a credit can be claimed for only one volunteer position for that month.

42.49(3) *Verification of eligibility for the tax credit.* An individual is required to have a written statement from the fire chief or other appropriate supervisor verifying that the individual was a volunteer fire fighter or volunteer EMS personnel for the months for which the tax credit is being claimed. Beginning with the 2014 tax year, an individual who is a reserve peace officer must have a written statement from the chief of police, sheriff, commissioner of public safety, or other appropriate supervisor verifying that the individual was a reserve peace officer for the months for which the tax credit is being claimed. The written statement does not have to be attached to a tax return claiming the credit. However, the individual may be requested to provide the written statement upon request by the department.

This rule is intended to implement Iowa Code section 422.12 as amended by 2014 Iowa Acts, House File 2459.

[**ARC 0398C**, IAB 10/17/12, effective 11/21/12; **ARC 1665C**, IAB 10/15/14, effective 11/19/14]

701—42.50(422) Taxpayers trust fund tax credit. For tax years beginning on or after January 1, 2013, a taxpayers trust fund tax credit is available for Iowa individual income tax. The credit is available for all individual income tax filers, including residents, nonresidents and part-year residents of Iowa, and individuals who file as part of a composite return as described in rule 701—48.1(422), as long as the Iowa return is filed within the extended due date to file an Iowa return. Therefore, a fiscal-year filer whose tax year does not begin on January 1 is eligible to claim the taxpayers trust fund tax credit as long as the return is filed within the extended due date of the Iowa return.

42.50(1) *Calculation of the amount of tax credit.* The credit is calculated by taking the amount in the Iowa taxpayers trust fund and dividing it by the number of individual income taxpayers who filed Iowa returns by October 31 of the year preceding the year in which the credit is allowed.

EXAMPLE: There is $120 million in the Iowa taxpayers trust fund at the end of the fiscal year ending June 30, 2013. There were 2,200,000 individuals who filed Iowa income tax returns by October 31, 2013, for tax years beginning on or after January 1, 2012, but beginning before January 1, 2013. This results in an Iowa taxpayers trust fund tax credit of $54 for the tax year beginning on or after January 1, 2013, but beginning before January 1, 2014 ($120,000,000 divided by 2,200,000 equals $54.55, which is rounded down to the nearest whole dollar). All taxpayers who file their Iowa individual income tax return by October 31, 2014, for the tax period beginning on or after January 1, 2013, but beginning before January 1, 2014, will be entitled to claim a $54 Iowa taxpayers trust fund tax credit.

If the amount of Iowa taxpayers trust fund tax credits claimed on tax returns for a particular year is less than the amount authorized, the difference will be transferred to the Iowa taxpayers trust fund for the next year and will be available as an Iowa taxpayers trust fund tax credit for the next year. There must be a balance in the Iowa taxpayers trust fund of at least $30 million in order for the Iowa taxpayers trust fund tax credit to be available.

EXAMPLE: There is $120 million in the Iowa taxpayers trust fund at the end of the fiscal year ending June 30, 2013. The total amount of Iowa taxpayers trust fund tax credit claimed on Iowa tax returns for tax years beginning on or after January 1, 2013, but beginning before January 1, 2014, which were filed on or before October 31, 2014, is $90 million. The difference of $30 million will be transferred to the Iowa taxpayers trust fund for the fiscal year ending June 30, 2014. The legislature approves an additional $60 million to be deposited in the Iowa taxpayers trust fund for the fiscal year ending June 30, 2014. This will result in $90 million in the Iowa taxpayers trust fund for the fiscal year ending June 30, 2014. If 2,200,000 individuals file Iowa individual income tax returns for tax years beginning on or after January 1, 2013, but beginning before January 1, 2014, by October 31, 2014, this will result in a $40 Iowa taxpayers trust fund tax credit for the tax year beginning on or after January 1, 2014, but beginning before January 1, 2015 ($90,000,000 divided by 2,200,000 equals $40.90, which is rounded down to the nearest whole dollar).

42.50(2) *Claiming the credit on the tax return.* The Iowa taxpayers trust fund is claimed on the amount of Iowa tax computed after all other nonrefundable credits allowed in division II of Iowa Code

chapter 422 (excluding the Iowa taxpayers trust fund tax credit) are deducted, after the amount of school district surtax described in rule 701—42.1(257,422) and emergency medical services income surtax described in rule 701—42.2(422D) is added, and after all refundable credits (excluding estimated payments and tax withheld) allowed in division II of Iowa Code chapter 422 are deducted. Any Iowa taxpayers trust fund tax credit in excess of the tax liability is not refundable and shall not be carried back to the tax year prior to the tax year in which the credit is claimed and cannot be carried forward to a tax year for any following year.

EXAMPLE: A taxpayer reported a tax liability of $100 on the taxpayer's 2013 Iowa income tax return. The taxpayer claimed a $40 personal exemption credit and a $25 franchise tax credit. This resulted in tax due of $35 before applying the school district surtax. Taxpayer was subject to a $2 school district surtax which resulted in total tax due of $37. Taxpayer was entitled to claim a $54 Iowa taxpayers trust fund tax credit, but only $37 of credit could be applied on the 2013 Iowa return. The remaining $17 of credit cannot be refunded, cannot be applied to a prior year tax liability, and cannot be carried forward to be applied to a subsequent year tax liability.

This rule is intended to implement Iowa Code section 422.11E.

[**ARC 1102C**, IAB 10/16/13, effective 11/20/13; **ARC 1665C**, IAB 10/15/14, effective 11/19/14]

701—42.51(422,85GA,SF452) From farm to food donation tax credit. Effective for tax years beginning on or after January 1, 2014, a taxpayer that donates a food commodity that the taxpayer produces may claim a tax credit for Iowa individual income tax. The credit is equal to 15 percent of the value of the commodities donated during the tax year for which the credit is claimed or $5,000, whichever is less. The value of the commodities shall be determined in the same manner as a charitable contribution of food for federal tax purposes under Section 170(e)(3)(C) of the Internal Revenue Code.

To qualify for the tax credit, the taxpayer (1) must produce the donated food commodity; (2) must transfer title to the donated food commodity to an Iowa food bank or Iowa emergency feeding organization recognized by the department; and (3) shall not receive remuneration for the transfer. The donated food commodity cannot be damaged or out-of-condition and declared to be unfit for human consumption by a federal, state, or local health official. A food commodity that meets the requirements for donated foods pursuant to the federal Emergency Food Assistance Program satisfies this requirement.

To be recognized by the department, a food bank or emergency feeding organization must either be a recognized affiliate of one of the eight partner food banks with the Iowa Food Bank Association or must register with the department. To register with the department, the organization must meet the definition of "emergency feeding organization," "food bank," or "food pantry" as defined by the department of human services in 441—66.1(234). The department of revenue will make registration forms available on the department's Web site. The department will maintain a list of recognized organizations on the department's Web site.

Food banks and emergency feeding organizations that receive eligible donations shall be required to issue receipts in a format prescribed by the department for all donations received and must annually submit to the department a receipt log of all the receipts issued during the tax year. The receipt log must be submitted in the form of a spreadsheet with column specifications as provided by the department. Receipt logs showing the donations for the previous calendar year must be delivered electronically or mailed to the department postmarked by January 15 of each year. If a receipt for a taxpayer's claim is not provided by the organization, the taxpayer's claim will be denied.

To claim the credit, a taxpayer shall submit to the department the original receipts that were issued by the food bank or emergency feeding organization. The receipt must include quantity information completed by the food bank or emergency feeding organization, taxpayer information, and a donation valuation consistent with Section 170(e)(3)(C) of the Internal Revenue Code completed by the taxpayer. Claims must be postmarked on or before January 15 of the year following the tax year for which the claim is requested. Once the department verifies the amount of the tax credit, a letter will be sent to the taxpayer providing the amount of the tax credit and a tax credit certificate number.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is earlier. The tax credit shall not be carried back to a tax year prior to the year in which the owner redeems the credit. The credit is not transferable to any other person other than the taxpayer's estate or trust upon the death of the taxpayer.

If the producer is a partnership, limited liability company, S corporation, estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement 2013 Iowa Acts, Senate File 452, division XVIII.
[**ARC 1138C**, IAB 10/30/13, effective 12/4/13]

701—42.52(422) Adoption tax credit. Effective for tax years beginning on or after January 1, 2014, an adoption tax credit is available for individual income tax equal to the amount of qualified adoption expenses paid or incurred by a taxpayer related to the adoption of a child during the tax year, not to exceed $2,500 per adoption.

42.52(1) *Definitions.* The following definitions are applicable to this rule:

"Adoption" means the permanent placement in Iowa of a child by the department of human services, by a licensed agency under Iowa Code chapter 238, by an agency that meets the provision of the interstate compact in Iowa Code section 232.158, or by a person making an independent placement according to the provisions of Iowa Code chapter 600.

"Child" means an individual who is under the age of 18 years.

"Qualified adoption expenses" means unreimbursed expenses paid or incurred in connection with the adoption of a child, including medical and hospital expenses of the biological mother which are incident to the child's birth, welfare agency fees, legal fees, and all other fees and costs related to the adoption of a child. Expenses which are eligible for the federal adoption credit as provided in Section 23(d)(1) of the Internal Revenue Code will be considered qualified adoption expenses. Expenses paid or incurred in violation of state or federal law are not qualified adoption expenses.

42.52(2) *Claiming the credit.* The first $2,500 of qualified adoption expenses is eligible for the credit. If the qualified adoption expenses are less than $2,500, then the total amount of qualified expenses can be claimed as a credit. Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year. The amount of tax credit claimed cannot be used as an itemized deduction for adoption expenses provided in 701—subrule 41.5(3).

This rule is intended to implement 2014 Iowa Acts, House File 2468.
[**ARC 1665C**, IAB 10/15/14, effective 11/19/14]

701—42.53(15) Workforce housing tax incentives program. Effective July 1, 2014, a business which qualifies under the workforce housing tax incentives program is eligible to receive tax incentives for individual income tax. The workforce housing tax incentives program replaces the eligible housing business enterprise zone program. An eligible business under the workforce housing tax incentives program must be approved by the economic development authority and must meet the requirements of 2014 Iowa Acts, House File 2448, section 15. The administrative rules for the workforce housing tax incentives program for the economic development authority may be found at 261—Chapter 48.

42.53(1) *Definitions.*

"Costs directly related" means expenditures that are incurred for construction of a housing project to the extent that they are attributable directly to the improvement of the property or its structures. "Costs directly related" includes expenditures for property acquisition, site preparation work, surveying, construction materials, construction labor, architectural services, engineering services, building permits, building inspection fees, and interest accrued on a construction loan during the time period allowed for project completion under an agreement entered into pursuant to the program. "Costs directly related" does not include expenditures for furnishings, appliances, accounting services, legal services, loan origination and other financing costs, syndication fees and related costs, developer fees, or the costs

associated with selling or renting the dwelling units whether incurred before or after completion of the housing project.

"Qualifying new investment" means costs that are directly related to the acquisition, repair, rehabilitation, or redevelopment of a housing project in this state. For purposes of this rule, "costs directly related to acquisition" includes the costs associated with the purchase of real property or other structures. "Qualifying new investment" includes costs that are directly related to new construction of dwelling units if the new construction occurs in a distressed workforce housing community. The amount of costs that may be used to compute "qualifying new investment" shall not exceed the costs used for the first $150,000 of value for each dwelling unit that is part of a housing project.

"Qualifying new investment" does not include the following:

1. The portion of the total cost of a housing project that is financed by federal, state, or local government tax credits, grants, forgivable loans, or other forms of financial assistance that do not require repayment, excluding the tax incentives provided under this program.

2. If a housing project includes the rehabilitation, repair, or redevelopment of an existing multi-use building, the portion of the total acquisition costs of the multi-use building, including a proportionate share of the total acquisition costs of the land upon which the multi-use building is situated, that are attributable to the street-level ground story that is used for a purpose that is other than residential.

3. Any costs, including acquisition costs, incurred before the housing project is approved by the economic development authority.

42.53(2) *Workforce housing tax incentives.* The economic development authority will allocate no more than $20 million in tax incentives for this program for any fiscal year. A housing business that has entered into an agreement with the economic development authority is eligible to receive the tax incentives described in the following paragraphs:

a. Sales tax refund. A housing business may claim a refund of the sales and use tax described in rule 701—12.9(15).

b. Investment tax credit. A housing business may claim a tax credit in an amount not to exceed 10 percent of the qualifying new investment in a housing project. An individual may claim a tax credit if the housing business is a partnership, limited liability company, S corporation, estate, or trust electing to have income taxed directly to the individual. The amount claimed by the individual shall be based upon the pro rata share of the individual's earnings from the partnership, limited liability company, S corporation, estate, or trust. Any tax credit in excess of the taxpayer's liability for the tax year is not refundable but may be credited to the tax liability for the following five years or until depleted, whichever is earlier.

42.53(3) *Claiming the tax credit.* The taxpayer must receive a tax credit certificate from the economic development authority to claim the eligible housing business tax credit. The tax credit certificate shall include the taxpayer's name, the taxpayer's address, the taxpayer's tax identification number, the date the project was completed, the amount of the eligible housing business tax credit and the tax year for which the credit may be claimed. In addition, the tax credit certificate shall include a place for the name and tax identification number of a transferee and the amount of the tax credit being transferred, as provided in subrule 42.53(5). The tax credit certificate must be included with the income tax return for the tax period in which the housing is ready for occupancy.

42.53(4) *Basis adjustment.* The increase in the basis of the property that would otherwise result from the qualifying new investment shall be reduced by the amount of the investment tax credit. For example, if a new housing project had qualifying new investment of $1 million which resulted in a $100,000 investment tax credit for Iowa tax purposes, the basis of the property for Iowa income tax purposes would be $900,000.

42.53(5) *Transfer of the credit.* Tax credit certificates issued under an agreement entered into pursuant to subrule 42.53(3) may be transferred to any person. Within 90 days of transfer, the transferee shall submit the transferred tax credit certificate to the department of revenue along with a statement containing the transferee's name, tax identification number, and address, the denomination that each replacement tax credit certificate is to carry, and any other information required by the department of revenue. However, tax credit certificate amounts of less than the minimum amount established in

rule by the economic development authority shall not be transferable. Within 30 days of receiving the transferred tax credit certificate and the transferee's statement, the department of revenue shall issue one or more replacement tax credit certificates to the transferee. Each replacement tax credit certificate must contain the information required for the original tax credit certificate and must have the same expiration date that appeared on the transferred tax credit certificate. A tax credit shall not be claimed by a transferee under this rule until a replacement tax credit certificate identifying the transferee as the proper holder has been issued. The transferee may use the amount of the tax credit transferred for any tax year the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit shall not be deducted from Iowa taxable income for individual income, corporation income, or franchise tax purposes.

42.53(6) *Repayment of benefits.* If the housing business fails to maintain the requirements of Iowa Code section 15.353, the taxpayer may be required to repay all or a portion of the tax incentives the taxpayer received. Irrespective of the fact that the statute of limitations to assess the taxpayer for repayment of the income tax credit may have expired, the department may proceed to collect the tax incentives forfeited by failure of the taxpayer to maintain the requirements of 2014 Iowa Acts, House File 2448, section 15. This repayment is required because it is a recovery of an incentive, rather than an adjustment to the taxpayer's tax liability. Details on the calculation of the repayment can be found in 261—subrule 187.5(4) of the administrative rules of the economic development authority. If the business is a partnership, limited liability company, S corporation, estate or trust where the income of the taxpayer is taxed to the individual owner(s) of the business, the department may proceed to collect the tax incentives against the partners, members, shareholders or beneficiaries to whom the tax incentives were passed through. See Decision of the Administrative Law Judge in *Damien & Colette Trebilcock, et al.,* Docket No. 11DORF 042-044, June 11, 2012.

This rule is intended to implement 2014 Iowa Acts, House File 2448.

[**ARC 1744C**, IAB 11/26/14, effective 12/31/14]

701—42.54(404A,422) Historic preservation and cultural and entertainment district tax credit for projects with Part 2 applications approved on or after July 1, 2014, and agreements entered into on or after July 1, 2014. The department of cultural affairs is authorized by the general assembly to award tax credits for a percentage of the qualified rehabilitation expenditures on a qualified rehabilitation project as described in the historic preservation and cultural and entertainment district tax credit program, Iowa Code chapter 404A. The program is administered by the department of cultural affairs with the assistance of the department of revenue. The general assembly has mandated that the department of cultural affairs and the department of revenue adopt rules to jointly administer Iowa Code chapter 404A. In general, the department of cultural affairs is responsible for evaluating whether projects comply with the prescribed standards for rehabilitation while the department of revenue is responsible for evaluating whether projects comply with the tax aspects of the program.

2014 Iowa Acts, House File 2453, amended the historic preservation and cultural and entertainment district tax credit program effective July 1, 2014. The department of revenue's provisions for projects with Part 2 applications approved and tax credits reserved prior to July 1, 2014, are found in rule 701—42.19(404A,422). The department of revenue's provisions for projects with Part 2 applications approved on or after July 1, 2014, and with agreements entered into on or after July 1, 2014, are found in this rule. The department of cultural affairs' rules related to this program may be found at 223—Chapter 48. Division I of 223—Chapter 48 applies to projects with tax credit reservations approved prior to July 1, 2014. Division II of 223—Chapter 48 applies to projects with Part 2 applications approved on or after July 1, 2014, and agreements entered into on or after July 1, 2014.

Notwithstanding anything contained herein to the contrary, the department of cultural affairs shall not reserve tax credits under 2013 Iowa Code chapter 404A as amended by 2013 Iowa Acts, chapter 112, section 1, for applicants that do not have an approved Part 2 application and a tax credit reservation on or before June 30, 2014. Projects with approved Part 2 applications and provisional tax credit reservations on or before June 30, 2014, shall be governed by 2013 Iowa Code chapter 404A as amended by 2013

Iowa Acts, chapter 112, section 1; by 223—Chapter 48, Division I; and by rule 701—42.19(404A,422). Projects for which Part 2 applications were approved and agreements entered into after June 30, 2014, shall be governed by 2014 Iowa Acts, House File 2453; by 223—Chapter 48, Division II; and by this rule.

42.54(1) *Application, registration, and agreement for the historic preservation and cultural and entertainment district tax credit.* Taxpayers that want to claim an income tax credit for completing a qualified rehabilitation project must submit an application for approval of the project. The application forms and instructions for the historic preservation and cultural and entertainment district tax credit are available on the department of cultural affairs' Web site. Once a project is registered, the taxpayer must enter into an agreement with the department of cultural affairs to be eligible for the credit.

42.54(2) *Computation of the amount of the historic preservation and cultural and entertainment district tax credit.* The amount of the historic preservation and cultural and entertainment district tax credit is a maximum of 25 percent of the qualified rehabilitation expenditures verified by the department of cultural affairs and the department of revenue following project completion, up to the amount specified in the agreement between the taxpayer and the department of cultural affairs.

42.54(3) *Qualified rehabilitation expenditures.* "Qualified rehabilitation expenditures" means the same as defined in rule 223—48.22(404A) of the historical division of the department of cultural affairs. In general, the department of cultural affairs evaluates whether expenditures comply with the prescribed standards for rehabilitation while the department of revenue evaluates whether expenditures comply with the tax requirements to be considered qualified rehabilitation expenditures, including whether the expenditures are in accordance with the requirements of Internal Revenue Code Section 47 and its related regulations.

a. Type of property and services eligible. In accordance with Iowa Code section 404A.1(6), the types of property and services claimed for the state tax credit must be "qualified rehabilitation expenditures" in accordance with Internal Revenue Code Section 47. Notwithstanding the foregoing sentence, expenditures incurred by an eligible taxpayer that is a nonprofit organization as defined in Iowa Code section 404A.1(4) shall be considered "qualified rehabilitation expenditures" if they are for "structural components," as that term is defined in Treasury Regulation § 1.48-1(e)(2), and for amounts incurred for architectural and engineering fees, site survey fees, legal expenses, insurance premiums, development fees and other construction-related costs.

b. Effect of financing sources on eligibility of expenditures. Qualified rehabilitation expenditures do not include expenditures financed by federal, state, or local government grants or forgivable loans unless otherwise allowed under Section 47 of the Internal Revenue Code. For an eligible taxpayer that is a nonprofit organization as defined in Iowa Code section 404A.1(4) that is not eligible for the federal rehabilitation credit, or another person that is not eligible for the federal rehabilitation credit, expenditures financed with federal, state, or local government grants or forgivable loans are not qualified rehabilitation expenditures.

42.54(4) *Completion of the qualified rehabilitation project and claiming the tax credit on the Iowa return.* After the taxpayer completes a qualified rehabilitation project, the taxpayer will be issued a certificate of completion of the project from the department of cultural affairs if the project complies with the federal standards, as defined in rule 223—48.22(404A). After the department of cultural affairs and the department of revenue verify the taxpayer's eligibility for the tax credit, the department of cultural affairs shall issue a tax credit certificate. For the taxpayer to claim the credit, the certificate must be included with the taxpayer's income tax return for the tax year in which the rehabilitation project is completed or the year in which the certificate is issued, whichever is later.

a. Information required. The tax credit certificate shall include the taxpayer's name, the taxpayer's address, the taxpayer's tax identification number, the address or location of the rehabilitation project, the date the project was completed and the amount of the historic preservation and cultural and entertainment district tax credit. In addition, the tax credit certificate shall include a place for the name and tax identification number of a transferee and the amount of the tax credit being transferred, as provided in subrule 42.54(5). In addition, if the taxpayer is a partnership, limited liability company, estate or trust, and the tax credit is allocated to the owners or beneficiaries of the entity, a list of the

owners or beneficiaries and the amount of credit allocated to each owner or beneficiary shall be provided with the certificate. The tax credit certificate shall be included with the income tax return for the period in which the project was completed or in which the certificate is issued, whichever is later.

b. Refund or carryforward. Any historic preservation and cultural and entertainment district tax credit in excess of the taxpayer's tax liability is fully refundable with interest computed under Iowa Code section 422.25. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

c. Allocation of historic preservation and cultural and entertainment district tax credits to the individual owners of the entity. A partnership, limited liability company or S corporation may designate the amount of the tax credit to be allocated to each partner, member or shareholder. The credit does not have to be allocated based on the pro rata share of earnings of the partnership, limited liability company or S corporation.

42.54(5) *Transfer of the historic preservation and cultural and entertainment district tax credit.* The historic preservation and cultural and entertainment district tax credit certificates may be transferred to any person or entity. The transferee may use the amount of the tax credit transferred against the taxes imposed in Iowa Code chapter 422, divisions II, III, and V, and in Iowa Code chapter 432, for any tax year the original transferor could have claimed the tax credit. Any credit in excess of the transferee's tax liability is not refundable. A tax credit certificate of less than $1,000 shall not be transferable.

a. Transfer process—information required. Within 90 days of transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the department of revenue along with a statement that contains the transferee's name, address and tax identification number, the amount of the tax credit being transferred, the amount of all consideration provided in exchange for the tax credit and the names of recipients of any consideration provided in exchange for the tax credit. If a payment of money was any part of the consideration provided in exchange for the tax credit, the transferee shall list the amount of the payment of money in its statement to the department of revenue. If any part of the consideration provided in exchange for the tax credit included nonmonetary consideration, including but not limited to any promise, representation, performance, discharge of debt or nonmonetary rights or property, the tax credit transferee shall describe the nature of the nonmonetary consideration and disclose any value the transferor and transferee assigned to the nonmonetary consideration. The tax credit transferee must indicate on its statement to the department of revenue if no consideration was provided in exchange for the tax credit. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee, the department of revenue will issue the replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company or S corporation, the transferee shall provide a list of the partners, members or shareholders and information on how the historic preservation and cultural and entertainment district tax credit should be divided among the partners, members or shareholders. The transferee shall also provide the tax identification numbers and addresses of the partners, members or shareholders. The certificate must have the same information required for the original tax certificate and must have the same expiration date as the original tax credit certificate. The transferee may not claim a tax credit until a replacement certificate identifying the transferee as the proper holder has been issued.

b. Consideration. Any consideration received for the transfer of the tax credit shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

42.54(6) *Appeals.* Challenges to an action by the department of revenue related to tax credit transfers, the claiming of tax credits, tax credit revocation, or repayment or recovery of tax credits must be brought pursuant to 701—Chapter 7.

This rule is intended to implement Iowa Code chapter 404A as amended by 2014 Iowa Acts, House File 2453, and Iowa Code section 422.11D.

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◊ Two or more ARCs

CHAPTER 162
SURFACE TRANSPORTATION BLOCK GRANT PROGRAM

761—162.1(86GA,SF2320) Purpose. Federal authorization acts appropriate funds to states to support surface transportation investments. A portion of these funds are provided to the state of Iowa for the Surface Transportation Block Grant Program. The purpose of these rules is to establish requirements for the Surface Transportation Block Grant Program.
[**ARC 2745C**, IAB 10/12/16, effective 10/1/16; **ARC 2843C**, IAB 12/7/16, effective 1/11/17]

761—162.2(86GA,SF2320) Contact information. Information relating to this chapter may be obtained from the Office of Program Management, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; telephone (515)239-1661.
[**ARC 2745C**, IAB 10/12/16, effective 10/1/16; **ARC 2843C**, IAB 12/7/16, effective 1/11/17]

761—162.3(86GA,SF2320) Source of funds. The Surface Transportation Block Grant Program established in 23 U.S.C. Section 133 provides for the use of federal funds to preserve and improve the condition and performance of any federal-aid highway, bridge or tunnel project on any public road. Surface Transportation Block Grant funds may also be used on pedestrian and bicycle infrastructure and transit capital projects including intercity bus terminals.
[**ARC 2745C**, IAB 10/12/16, effective 10/1/16; **ARC 2843C**, IAB 12/7/16, effective 1/11/17]

761—162.4(86GA,SF2320) Administration of funds. Surface Transportation Block Grant funds are administered by the department and shall be made available for obligation throughout the state on a fair and equitable basis. The department, in consultation with city, county and local planning agency officials, through their representative organizations, shall allocate these funds to Iowa's transportation management areas, metropolitan planning organizations, regional planning affiliations, incorporated cities, counties and the department. Allocation of these funds shall be based upon a distribution methodology approved by the commission. The commission shall review and approve the distribution methodology upon passage of each federal authorization act. Funds allocated to cities and counties to support the Federal-Aid Highway Bridge Program shall be made in accordance with 761—Chapter 161. All allocations of the Surface Transportation Block Grant funds shall be made in accordance with the Federal Highway Administration's regulations and include the allocations of the Surface Transportation Program (STP) Set-Aside for transportation alternatives as established in 23 U.S.C. Section 133(h).

These rules are intended to implement 2016 Iowa Acts, Senate File 2320, section 4.
[**ARC 2745C**, IAB 10/12/16, effective 10/1/16; **ARC 2843C**, IAB 12/7/16, effective 1/11/17]

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CHAPTER 821
HIGHWAY-RAILROAD GRADE CROSSING SURFACE REPAIR FUND

[Substance formerly in (06,C)Ch 3]
[Prior to 6/3/87, Transportation Department [820]—(10,B)Ch 5]

761—821.1(327G) Definitions. The following terms when used in this chapter shall have the following meanings:

"Grade crossing surface repair" means the partial or complete renovation of a highway-railroad grade crossing and the highway approaches to the crossing.

"Jurisdiction" means the authority having primary control over a highway, street, or alley.

"Repair fund" means the grade crossing surface repair fund established in Iowa Code section 327G.29 and administered by the department.

761—821.2(327G) General information.

821.2(1) The repair fund shall be used for grade crossing surface repair.

821.2(2) Program information, applications and application instructions are available on the department's Web site at www.iowadot.gov. The program is administered by the Office of Rail Transportation, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; telephone (515)239-1108.

[**ARC 2842C**, IAB 12/7/16, effective 1/11/17]

761—821.3(327G) Procedures for the use of grade crossing surface repair funds.

821.3(1) *Use of funds.* A portion of the repair fund, not to exceed 50 percent in any fiscal year, shall be set aside to meet critical or atypical needs. In identifying priorities for the set-aside funds, criteria including, but not limited to, the following shall be considered:

a. Condition of the crossing.

b. Safety concerns.

c. Utilization of the rail line.

d. Train and motor vehicle traffic density at the site. Special consideration may be given to heavy truck traffic.

e. Recent or planned development or construction in the vicinity of the crossing.

821.3(2) *Notification to department.* If a railroad and a jurisdiction agree to use the repair fund for grade crossing surface repair, written notification of the action signed by both parties shall be sent to the department.

a. The notification shall include the American Association of Railroads—Department of Transportation (AAR-DOT) crossing number, the total estimated cost of the repair, and a statement that the railroad and the jurisdiction each agree to pay 20 percent of the cost of the repair.

b. Notification shall be accepted by the department in order of receipt.

821.3(3) *Processing an agreement.*

a. The department shall determine if the agreed-upon work constitutes grade crossing surface repair and may consult with the jurisdiction or the railroad if further information is needed.

b. If the work constitutes grade crossing surface repair and when funds are available in the repair fund, the department shall furnish the railroad and the jurisdiction with three copies of an agreement for grade crossing surface repair.

c. The railroad and the jurisdiction shall sign all three copies of the agreement and return them to the department.

d. The department shall:

(1) Approve the agreement and obligate from the repair fund an amount equal to 60 percent of the cost of the agreed-upon work.

(2) Sign all three copies of the agreement, retain one copy of the fully executed agreement, transmit one copy to the jurisdiction, and transmit one copy to the railroad, authorizing work to proceed.

821.3(4) *Preaudit.* Prior to approval of the agreement, the department may perform a preaudit evaluation of the railroad.

The preaudit evaluation may include an examination of the railroad's accounting methods and procedures to determine the railroad's ability to segregate and accumulate costs to be charged against the surface repair project; an examination of the railroad's cost factors to ensure their propriety and allowability; and an examination of any other general information available which might be pertinent or necessary in determining the railroad's auditability.

821.3(5) *Review of completed project.* Upon completion of the agreed-upon work, the department, the railroad and the jurisdiction shall review the project to determine satisfactory completion.

821.3(6) *Project billing and payment.*

a. The railroad shall submit to the jurisdiction and the department a final detailed billing covering the actual and necessary costs incurred by the railroad for the agreed-upon work.

b. The jurisdiction and the department shall review the billing for reasonable conformance with the agreement. The department may audit the billing to determine the allowability and propriety of the billing costs in accordance with the agreement.

c. Once the department approves the billing, the department shall pay to the railroad from the repair fund an amount equal to 60 percent of the actual cost of the agreed-upon work.

d. The jurisdiction shall pay to the railroad an amount equal to 20 percent of the actual cost of the agreed-upon work.

[**ARC 2842C**, IAB 12/7/16, effective 1/11/17]

These rules are intended to implement Iowa Code sections 312.2(2), 327G.29 and 327G.30.

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