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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

Utilities Division[199]

Replace Chapter 1
Replace Chapter 4
Replace Chapters 6 to 8
Replace Chapters 10 and 11
Replace Chapter 13
Replace Chapters 19 to 22
Replace Chapters 24 to 26
Replace Chapter 37
Replace Chapter 39

Human Services Department[441]

Replace Analysis
Replace Chapter 58
Replace Chapters 77 to 79
Replace Chapter 101
Replace Chapter 103

Inspections and Appeals Department[481]

Replace Analysis
Remove Reserved Chapters 11 to 21
Insert Chapter 11 and Reserved Chapters 12 to 21

State Public Defender[493]

Replace Analysis
Replace Chapter 7
Replace Chapters 11 and 12

Revenue Department[701]

Replace Chapter 10

CHAPTER 1
ORGANIZATION AND OPERATION
[Prior to 10/8/86, Commerce Commission[250]]

199—1.1(17A,474) Purpose. This chapter describes the organization and operation of the Iowa utilities board (hereinafter referred to as board) including the offices where, and the means by which any interested person may obtain information and make submittals or requests.

199—1.2(17A,474) Scope of rules. Promulgated under Iowa Code chapters 17A and 474, these rules shall apply to all matters before the Iowa utilities board. No rule shall in any way relieve a utility or other person from any duty under the laws of this state.

199—1.3(17A,474,476,78GA,HF2206) Waivers. In response to a request, or on its own motion, the board may grant a waiver from a rule adopted by the board, in whole or in part, as applied to a specific set of circumstances, if the board finds, based on clear and convincing evidence, that:

1. The application of the rule would pose an undue hardship on the person for whom the waiver is requested;
2. The waiver would not prejudice the substantial legal rights of any person;
3. The provisions of the rule subject to a petition for waiver are not specifically mandated by statute or another provision of law; and
4. Substantially equal protection of public health, safety, and welfare will be afforded by a means other than that prescribed in the rule for which the waiver is requested.

The burden of persuasion rests with the person who petitions the board for the waiver. If the above criteria are met, a waiver may be granted at the discretion of the board upon consideration of all relevant factors.

Persons requesting a waiver may use the form provided in 199—subrule 2.2(17), or may submit their request as a part of another pleading. The waiver request must state the relevant facts and reasons the requester believes will justify the waiver, if they have not already been provided to the board in another pleading. The waiver request must also state the scope and operative period of the requested waiver. If the request is for a permanent waiver, the requester must state reasons why a temporary waiver would be impractical.

The waiver shall describe its precise scope and operative period. Grants or denials of waiver requests shall contain a statement of the facts and reasons upon which the decision is based. The board may condition the grant of the waiver on such reasonable conditions as appropriate to achieve the objectives of the particular rule in question. The board may at any time cancel a waiver upon appropriate notice and opportunity for hearing.

This rule is intended to implement Iowa Code chapters 17A, 474, and 476 and 2000 Iowa Acts, House File 2206.

199—1.4(17A,474) Duties of the board. The utilities board regulates electric, gas, telephone, telegraph, and water utilities; and pipelines and underground gas storage. The board regulates the rates and services of public utilities pursuant to Iowa Code chapter 476; certification of electric power generators pursuant to chapter 476A; construction and safety of electric transmission lines pursuant to chapter 478; and the construction and operation of pipelines and underground gas or hazardous liquid storage pursuant to chapters 479, 479A and 479B.

199—1.5(17A,474) Organization. The utilities division consists of the three-member board, the office of the executive secretary, which heads the technical and administrative staff, and the office of general counsel.

1.5(1) *The board.* The three-member board is the policy-making body for the utilities division. The chairperson serves as the administrator of the utilities division. As administrator, the chairperson is responsible for all administrative functions and decisions.

1.5(2) *General counsel.* The duties of the general counsel are prescribed by Iowa Code section 474.10. The general counsel acts as attorney for and legal advisor of the board and its staff and represents the board in all actions instituted in a state or federal court challenging the validity of any rule, regulation or order of the board.

1.5(3) *The office of the executive secretary.* The executive secretary is appointed by the board and is its chief operating officer and responsible for all technical staff. The executive secretary is also the custodian of the board seal and all board records. The executive secretary, deputy executive secretary, or secretary's designee is responsible for attesting to the signatures of the board members and placing the seal on original board orders. The executive secretary, deputy executive secretary, or the secretary's designee is responsible for certifying official copies of board documents. The executive secretary shall also be responsible for establishing procedures for the examination of board records by the general public pursuant to the provisions of Iowa Code section 22.11 and for providing for the enforcement of those procedures.

a. The deputy executive secretary assists the executive secretary in carrying out responsibilities and is responsible for preparing the agency budget and managing the records center, technical library, and receptionist area.

b. The customer service section serves as the agency's information contact and provides customer assistance and education for both the staff and the public. The section assists customers and competitors in resolving disputes with service providers. The section monitors customer service policies and practices, provides information to the public, and advises the board on customer service quality and issues of public concern.

c. The energy section is responsible for providing the board with recommendations for appropriate actions on energy matters. The section monitors activities of gas, electric, and water service providers. It also provides analysis and recommendations on tariff filings, rate proceedings, annual fuel purchase reviews, service territory disputes, and restructuring issues. The section advises the board on issues before the Federal Energy Regulatory Commission (FERC) and U.S. Department of Energy (DOE).

d. The information technology section is responsible for the development of electronic support and technology training for the division. This includes the development of a management information system and other database applications for the division. It also maintains the board's local area network system and provides all computer and technical support services and systems for the processing of information and records, including website development and maintenance, and monitoring incoming electronic messages and requests for information.

e. The policy development section provides professional and technical support to the industry sections and the board in the areas of policy development and research. In cases before the board, the section is responsible for the review and analysis of cost of capital, cost of service, and rate design. The section is responsible for performing analysis of competitive and restructuring issues, utility management performance, least cost alternatives, energy efficiency activities, and other public policy matters.

f. The safety and engineering section is responsible for the regulation of gas and electric providers and pipeline and electric transmission and distribution companies as it relates to safety, construction, and operation and maintenance of facilities. The section reviews and processes all petitions for electric transmission line franchises under Iowa Code chapter 478 and for pipeline permits under Iowa Code chapters 479 and 479B. It also acts as an agent for the federal Department of Transportation in pipeline safety matters.

g. The telecommunications section is responsible for providing the board with recommendations for appropriate actions on telecommunications matters. The section monitors activities of telecommunications service providers. It also provides analysis and recommendations of telecommunications providers' filings, rate proceedings, and advises the board on ratemaking and restructuring issues. The section advises the board on issues before the Federal Communications Commission (FCC).

199—1.6(68B) Consent for the sale or lease of goods and services. An official or employee shall not sell or lease, either directly or indirectly, any goods or services to individuals, associations, or

corporations subject to the regulatory authority of the board without complying with the provisions of rule 351—6.11(68B) of the Iowa ethics and campaign disclosure board.

1.6(1) *General prohibition.* Rescinded IAB 8/16/06, effective 9/20/06.

1.6(2) *Definitions.* Rescinded IAB 8/16/06, effective 9/20/06.

1.6(3) *Application for consent.* Rescinded IAB 8/16/06, effective 9/20/06.

1.6(4) *Conditions of consent for officials.* Rescinded IAB 8/16/06, effective 9/20/06.

1.6(5) *Conditions of consent for employees.* Rescinded IAB 8/16/06, effective 9/20/06.

1.6(6) *Effect of consent.* Rescinded IAB 8/16/06, effective 9/20/06.

1.6(7) *Participation in utility programs.* Rescinded IAB 8/16/06, effective 9/20/06.

1.6(8) *Appeal.* Rescinded IAB 8/16/06, effective 9/20/06.

1.6(9) *Notice.* Rescinded IAB 8/16/06, effective 9/20/06.

199—1.7 Rescinded, effective January 1, 1984.

199—1.8(17A,474) Matters applicable to all proceedings.

1.8(1) *Communications.* All communications to the board shall be addressed to the Executive Secretary, Iowa Utilities Board, 1375 E. Court Avenue, Room 69, Des Moines, Iowa 50319-0069, unless otherwise specifically directed. Pleadings and other papers required to be filed with the board shall be filed in the office of the executive secretary of the board within the time limit, if any, for such filing. Unless otherwise specifically provided, all communications and documents are officially filed upon receipt at the office of the board.

1.8(2) *Office hours.* Office hours are 8 a.m. to 4:30 p.m., Monday to Friday. Offices are closed on Saturdays and Sundays and on official state holidays designated in accordance with state law. Time provisions for electronic filing are found at 199—14.9(17A,476).

1.8(3) *Sessions of the board.* The board shall be considered in session at the office of the board in Des Moines, Iowa, during regular business hours. When a quorum of the board is present, it shall be considered a session for considering and acting upon any business of the board. A majority of the board constitutes a quorum for the transaction of business.

1.8(4) *Cross reference to rules regarding electronic filing, placement of docket numbers on filings, service of documents, and required number of copies.* The board's rules regarding electronic filing are found at 199—Chapter 14. The board's rules regarding paper filing are found at 199—Chapter 7, including the board's rule regarding placement of docket numbers on filings at 199—subrule 7.4(3); the board's rule regarding service of documents at 199—subrule 7.4(6); and the board's rule regarding required number of copies of documents filed on paper at 199—subrule 7.4(4).
[Editorial change: IAC Supplement 12/29/10]

199—1.9(22) Public information and inspection of records.

1.9(1) *Public information.* Any interested person may examine all public records of the board by written request or in person at the offices of the board. Public records shall be examined only at the board during the board's regular business hours, Monday through Friday from 8 a.m. to 4:30 p.m., excluding legal holidays. Unless otherwise provided by law, all public records, other than confidential records, maintained by the board shall be made available for public inspection.

1.9(2) *Definitions.*

"Confidential records." Records not available for public inspection under state law.

"Personally identifiable information." Information about or pertaining to an individual. This does not include information pertaining to corporations.

"Public records." Records of or belonging to the board which are necessary to the discharge of its duties.

1.9(3) *Inspection of records.* Subrule 1.9(4) below lists those board records which are routinely available for public inspection in the board's records center. Procedures governing requests for inspection of the records are set out in subrule 1.9(7).

1.9(4) *Board records routinely available for public inspection.* In accordance with the provisions of the State Records Management Manual, the board collects and maintains the following records that are routinely available for public inspection:

a. Board calendars, agenda, news releases and other information intended for the public.

b. Board decisions, orders, opinions and other statements of law or policy issued by the board in the performance of its function.

c. The records of utility rate case proceedings.

d. The records of rule-making proceedings.

e. Annual reports of the board and annual reports filed with the board by public utilities.

f. Tariffs filed by a public utility showing the rates and charges for its services and the rules and regulations under which the services are furnished.

g. The records of formal utility service proceedings.

h. Documents relating to informal and formal complaints against utilities.

i. The records of formal utility investigations.

j. The records of utility depreciation proceedings.

k. Rulings on requests for waiver of board rules.

l. The records of the board's annual review of an electric or gas utility.

m. The records of proceedings for the issuance or amendment of an electric generator certificate.

n. Information on public utilities' energy conservation programs.

o. The records of formal proceedings for the issuance of an electric franchise or certificate.

p. The records of formal proceedings for the issuance of a permit to construct a pipeline or underground gas storage facility.

q. Petitions by a public utility for particular treatment of an extraordinary item under commission accounting rules.

r. The records of board proceedings on matters relating to electric and pipeline safety.

s. Public utility filings with the board relating to customer rights and remedies.

t. All other records that are not specifically exempted from disclosure by subrule 1.9(5).

The board's files of public records listed above may contain confidential records. Any request to review confidential records must be made in accordance with subrule 1.9(8). In addition, the board's records listed in *"b," "c," "e,"* and *"h"* may contain personally identifiable information.

Various legal and technical publications related to public utilities are also available for inspection by the public in the board's technical library.

1.9(5) *Records not routinely available for public inspection.* The following records are not routinely available for public inspection. The records are listed in this subrule by category, according to the statutory basis for withholding them from inspection.

a. Materials that are specifically exempted from disclosure by statute and which the board may in its discretion withhold from public inspection. Any person may request permission to inspect particular records withheld from inspection under this subrule. At the time of the request, the board will notify all interested parties. If the request is to review materials under subparagraphs 1.9(5)*"a"*(1) and 1.9(5)*"a"*(3), the board will withhold the materials from public inspection for 14 days to allow the party who submitted the materials an opportunity to seek injunctive relief. Records the commission is authorized to withhold from public inspection under Iowa law in its discretion include, but are not limited to, the following:

(1) Trade secrets recognized and protected as such by law. Iowa Code section 22.7.

(2) Records that represent and constitute the work product of an attorney, which are related to litigation or claim made by or against a public body. Iowa Code section 22.7.

(3) Reports made to the board which, if released, would give advantage to competitors and serve no public purpose. Iowa Code section 22.7.

(4) Personal information in confidential personnel records of the board. Iowa Code section 22.7.

(5) Communications not required by law, rule, or procedure that are made to a government body or to any of its employees by identified persons outside of government, to the extent that the government body receiving those communications could reasonably believe that those persons would

be discouraged from making them to the government body if they were available for general public examination. Notwithstanding this provision:

1. The communication is a public record to the extent the person outside of government making that communication consents to its treatment as a public record.

2. Information contained in the communication is a public record to the extent it can be disclosed without directly or indirectly indicating the identity of the person outside of government making it or enabling others to ascertain the identity of that person.

3. Information contained in the communication is a public record to the extent it indicates the date, time, specific location, and immediate facts and circumstances surrounding the occurrence of a crime or other illegal act, except to the extent its disclosure would plainly and seriously jeopardize a continuing investigation or pose a clear and present danger to the safety of any person. In any action challenging the failure of the lawful custodian to disclose any particular information of the kind enumerated in this paragraph, the burden of proof is on the lawful custodian to demonstrate the disclosure of that information would jeopardize such an investigation or would pose such a clear and present danger. Iowa Code section 22.7.

(6) Materials exempted from public inspection under any other provisions of state law.

b. Materials that are specifically exempted from disclosure by statute and which the board is prohibited from making available for public inspection. The board is required to withhold the following materials from public inspection:

(1) Tax records submitted to the board and required by it in the execution of its duties shall be held confidential. Iowa Code section 422.20.

(2) Reserved.

c. Materials exempted pursuant to requests deemed granted by the board. Requests to withhold from public inspection material or information that contains negotiated transportation rates and prices for natural gas supply, reservation charges for portfolio gas supply contracts, and terms and prices for all hedging activity including both financial hedges and weather-related information included in monthly purchased gas adjustment filings, annual purchase gas adjustment filings, annual purchased gas adjustment reconciliations, periodic filings related to changes in purchased gas adjustment factors, negotiated purchase prices for electric power, fuel, and transportation, customer-specific information, power supply bills in support of energy adjustment clause filings, network improvement and maintenance plans and related extensions and progress reports, wireless coverage area maps, service outage reports filed with the board pursuant to 199 IAC 39.5(5), or the financial records filed by applicants for certificates of convenience and necessity to provide competitive local exchange service shall be deemed granted pursuant to Iowa Code section 22.7(3), as a trade secret, or pursuant to Iowa Code section 22.7(6), as a report to a government agency which, if released, would benefit competitors and would serve no public purpose, or pursuant to both sections, provided that the confidential portions of the filings are identified and segregated and an attorney for the company or a corporate officer avers that those portions satisfy Iowa Code section 22.7(3) or 22.7(6), or both, as interpreted by the Iowa Supreme Court. The information shall be held confidential by the board upon filing and will be subject to the provisions of 199 IAC 1.9(8)*"b"*(3).

1.9(6) *Requests that materials or information submitted to the board be withheld from public inspection.* Any person submitting information or materials to the board may submit a request that part or all of the information or materials not be made available for public inspection pursuant to the following requirements.

a. Procedure. The materials to which the request applies shall be physically separated from any materials to which the request does not apply. The request shall be attached to the materials to which it applies. Each page of the materials to which the request applies shall be clearly marked confidential.

b. Content of request. Each request shall contain a statement of the legal basis for withholding the materials from inspection and the facts to support the legal basis relied upon. The facts underlying the legal basis shall be supported by affidavit executed by a corporate officer (or by an individual, if not a business entity) with personal knowledge of the specific facts. If the request is that the materials be withheld from inspection for a limited period of time, the period shall be specified.

c. Compliance. If a request complies with the requirements of paragraphs *"a"* and *"b"* of this subrule, the materials will be temporarily withheld from public inspection. The board will examine the documents to determine whether the documents should be afforded confidentiality. If the request is granted, the ruling will be placed in a public file in lieu of the materials withheld from public inspection.

d. Request denied. If a request for confidentiality is denied, the documents will be held confidential for 14 days to allow the applicant an opportunity to seek injunctive relief. After the 14 days expire, the materials will be available for public inspection, unless the board is directed by a court to keep the information confidential.

1.9(7) *Procedures for the inspection of commission records which are routinely available for public inspection.* The records in question must be reasonably described by the person requesting them to permit their location by staff personnel. Members of the public will not be given access to the area in which records are kept and will not be permitted to search the files.

Advance requests to have records available on a certain date may be made by telephone or by correspondence.

a. Search fees. An hourly fee will be charged for searching for requested records. The fee will be based upon the pay scale of the employee who makes the search. No search fee will be charged if the records are not located, the records are not made available for inspection, or the search does not exceed one-quarter hour in duration.

b. Written request. Written requests should list the telephone number (if any) of the person making the request, and for each document requested should set out all available information which would assist in identifying and locating the document. The request should also set out the maximum search fee the person making the request is prepared to pay. If the maximum search fee is reached before all of the requested documents have been located and copied, the requesting person will be notified. When the requesting person requests that the board mail copies of the materials, postage and handling expenses should also be included.

c. Procedure for written request. The records will be produced for inspection at the earliest possible date following a request. Records should be inspected within seven days after notice is given that the records have been located and are available for inspection. After seven days, the records will be returned to storage and additional charges may be imposed for having to produce them again.

d. Copies. Copies of public records may be made in the board's records and information center and the charge shall be the actual copying cost.

1.9(8) *Procedures for the inspection of board records which are not routinely available for public inspection.* Any person desiring to inspect board records which are not routinely available for public inspection shall file a request for inspection meeting the requirements of this subrule.

a. Content of request. The records must be reasonably described by the person requesting them, so as to permit their location by staff personnel. Requests shall be directed to the executive secretary of the board.

b. Procedure. Requests for inspection shall be acted upon as follows:

(1) If the board is prohibited from disclosing the records, the request for inspection will be denied with a statement setting forth the specific grounds for denial.

(2) If the board is prohibited from disclosing part of a document from inspection, that part will be deleted and the remainder will be made available for inspection.

(3) In the case of requests to inspect records not routinely available for public inspection under 1.9(5)*"a"*(1), 1.9(5)*"a"*(3), and 1.9(5)*"c,"* the board will notify all interested parties of the request to view the materials. The board will withhold the materials from public inspection for 14 days to allow the party who submitted the materials an opportunity to seek injunctive relief. If injunctive relief is not requested within this period, the records will be produced for inspection. Requests to review materials not routinely available for public inspection under any other category of paragraph 1.9(5)*"a"* will be acted upon by the board. If the request is granted by the board, or is partially granted and partially denied, the person who submitted the records to the board will be afforded 14 days from the date of the written ruling in which to seek injunctive relief. If injunctive relief is not requested within this period, the records will be produced for inspection.

1.9(9) *Procedures by which the subject of a confidential record may have a copy released to a named third party.* Upon a request which complies with the following procedures, the board will disclose a confidential record to its subject or to a named third party designated by the subject. Positive identification is required of all individuals making such a request.

a. In-person requests. Subjects of a confidential record who request that information be given to a named third party will be asked for positive means of identification. If an individual cannot provide suitable identification, the request will be denied.

Subjects of a confidential record who request that information be given to a named third party will be asked to sign a release form before the records are disclosed.

b. Written request. All requests by a subject of a confidential board record for release of the information to a named third party sent by mail shall be signed by the requester and shall include the requester's current address and telephone number (if any). If positive identification cannot be made on the basis of the information submitted along with the information contained in the record, the request will be denied.

Subjects of a confidential record who request by mail that information be given to a named third party will be asked to sign a release form before the records are disclosed.

c. Denial of access to the record. If positive identification cannot be made on the basis of the information submitted, and if data in the record is so sensitive that unauthorized access could cause harm or embarrassment to the individual to whom the record pertains, the board may deny access to the record pending the production of additional evidence of identity.

1.9(10) *Procedure by which the subject of a board record may have additions, dissents or objections entered into the record.* An individual may request an addition, dissent or an objection be entered into a board record which contains personally identifiable data pertaining to that individual. The request shall be acted on within a reasonable time.

a. Content of request. The request must be in writing and addressed to the executive secretary of the board. The request should contain the following information:

(1) A reasonable description of the pertinent record.

(2) Verification of identity.

(3) The requested addition, dissent or objection.

(4) The reason for the requested addition, dissent or objection to the record.

b. Denial of request. If the request is denied, the requester will be notified in writing of the refusal and will be advised that the requester may seek board review of the denial within ten working days after issuance of the denial.

1.9(11) *Advice and assistance.* Individuals who have questions regarding the procedures contained in these rules may contact the executive secretary of the board at the following address: Iowa Utilities Board, 1375 E. Court Avenue, Room 69, Des Moines, Iowa 50319-0069.

1.9(12) *Data processing system.* The board does not currently have a data processing system which matches, collates or permits the comparison of personally identifiable information in one record system with personally identifiable information on another record system.

[Editorial change: IAC Supplement 12/29/10]

These rules are intended to implement Iowa Code sections 17A.3, 68B.4, 474.1, 474.5, 474.10, 476.1, 476.2, 476.31 and 546.7.

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[Editorial change: IAC Supplement 12/29/10]

CHAPTER 4
DECLARATORY ORDERS

[Prior to 10/8/86, see Commerce Commission[250]]

199—4.1(17A) Petition for declaratory order. Any person may file a petition with the Iowa utilities board for a declaratory order as to the applicability to specified circumstances of a statute, rule, or order within the primary jurisdiction of the utilities board, at 1375 E. Court Avenue, Room 69, Des Moines, Iowa 50319-0069. A petition is deemed filed when it is received by that office. The utilities board shall provide the petitioner with a file-stamped copy of the petition if the petitioner provides the board with an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

STATE OF IOWA
BEFORE THE IOWA STATE UTILITIES BOARD

IN RE: THE PETITION OF (insert petitioner's name) FOR A DECLARATORY ORDER ON (insert rule number, statute, etc., for which interpretation is sought).	}	DOCKET NO.___ (completed by board) PETITION FOR DECLARATORY ORDER

COMES NOW (insert name of petitioner) and requests a declaratory order on (state rule number, statute, order, decision, or other written statement of law or policy of which an interpretation is sought), and in support petitioner states:

(The petition shall then set forth in separately numbered statements:)

1. A clear and concise statement of all relevant facts on which the ruling is requested.
2. A citation to and the relevant language of the specific statutes, rules, policies, decisions, or orders, the applicability of which has been questioned, and any other relevant law.
3. The questions petitioner wants answered, stated clearly and concisely.
4. The answers to the questions desired by the petitioner and a summary of the reasons urged by the petitioner in support of those answers.
5. The reasons for requesting the declaratory order and disclosure of the petitioner's interest in the outcome.
6. A statement indicating whether the petitioner is currently a party to another proceeding involving the questions at issue and whether, to the petitioner's knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity.
7. The names and addresses of other persons, or a description of any class of persons, known by petitioner to be affected by, or interested in, the questions presented in the petition.
8. Any request by petitioner for a meeting as provided for by rule 199—4.7(17A).

[The petition must be dated and signed by the petitioner or the petitioner's representative. It must also include the name, mailing address, and telephone number of the petitioner and petitioner's representative, and a statement indicating the person to whom communications concerning the petition should be directed.]

WHEREFORE, (insert petitioner's name) prays that the board issue a declaratory order on (insert proposed subject of the requested order).

Respectfully submitted,

_____
(Signature of petitioner or representative)
(Typed or printed name of signer)
(Address and telephone number)

[Editorial change: IAC Supplement 12/29/10]

199—4.2(17A) Notice of petition. Within five days after receipt of a petition for a declaratory order, the utilities board shall give notice to all persons not served by the petitioner pursuant to rule 199—4.6(17A)

to whom notice is required by any provision of law. The utilities board may also give notice to any other persons.

199—4.3(17A) Intervention.

4.3(1) Persons who qualify under any applicable provision of law as an intervenor and who file a petition for intervention within 14 days of the filing of a petition for declaratory order shall be allowed to intervene in a proceeding for a declaratory order.

4.3(2) Any person who filed a petition for intervention at any time prior to the issuance of an order may be allowed to intervene in a proceeding for a declaratory order at the discretion of the utilities board.

4.3(3) A petition for intervention shall be filed at 1375 E. Court Avenue, Room 69, Des Moines, Iowa 50319-0069. Such a petition shall be deemed filed when it is received by that office. The utilities board will provide the petitioner with a file-stamped copy of the petition for intervention if the petitioner provides an extra copy for this purpose. A petition for intervention must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

STATE OF IOWA
BEFORE THE IOWA STATE UTILITIES BOARD

IN RE: THE PETITION OF (insert petitioner's name) FOR A DECLARATORY ORDER ON (insert rule number, statute, etc., for which interpretation is sought).	}	DOCKET NO.___ (insert docket number) PETITION FOR INTERVENTION

COMES NOW (insert name of petitioner) and requests intervention in this matter and in support petitioner states:

(The petition shall then set forth in separately numbered statements:)

1. Facts supporting the intervenor's standing and qualifications for intervention.
2. The answers urged by the intervenor to the question or questions presented and a summary of the reasons urged in support of those answers.
3. Reasons for requesting intervention and disclosure of the intervenor's interest in the outcome.
4. A statement indicating whether the intervenor is currently a party to another proceeding involving the questions at issue and whether, to the intervenor's knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity.
5. The names and addresses of other persons, or a description of any class of persons, known by the intervenor to be affected by, or interested in, the questions presented in the petition.
6. Whether the intervenor consents to be bound by the determination of the matters presented in the declaratory order proceeding.

[The petition must be dated and signed by the intervenor or the intervenor's representative. It must also include the name, mailing address, and telephone number of the intervenor and intervenor's representative, and a statement indicating the person to whom communications concerning the petition should be directed.]

WHEREFORE, (insert intervenor's name) prays that the board grant it intervention and issue a declaratory order on (insert proposed subject of the requested order).

Respectfully submitted,

_____
(Signature of intervenor or representative)
(Typed or printed name of signer)
(Address and telephone number)

[Editorial change: IAC Supplement 12/29/10]

199—4.4(17A) Briefs. The petitioner or any intervenor may file a brief in support of the position urged. The utilities board may request a brief from the petitioner, any intervenor, or any other person concerning the questions raised.

199—4.5(17A) Inquiries. Inquiries concerning the status of a declaratory order proceeding may be made to the Executive Secretary, Iowa Utilities Board, 1375 E. Court Avenue, Room 69, Des Moines, Iowa 50319-0069.
[Editorial change: IAC Supplement 12/29/10]

199—4.6(17A) Service and filing of petitions and other papers.

4.6(1) *When service required.* Except where otherwise provided by law, every petition for declaratory order, petition for intervention, brief, or other paper filed in a proceeding for a declaratory order shall be served upon each of the parties of record to the proceeding and on any persons who, based upon a reasonable investigation, would be a necessary party to the proceeding under applicable substantive law, simultaneously with their filing. The party filing a document is responsible for service on all parties and other required persons.

4.6(2) *Filing—when required.* All petitions for declaratory orders, petitions for intervention, briefs, or other papers filed in a proceeding for a declaratory order shall be filed with the Executive Secretary, Iowa Utilities Board, 1375 E. Court Avenue, Room 69, Des Moines, Iowa 50319-0069. All petitions, briefs, or other papers that are required to be served upon a party shall be filed simultaneously with the utilities board.

4.6(3) *Method of service, time of filing, and proof of mailing.* Method of service, time of filing, and proof of mailing shall be as provided by 199—subrule 7.6(1).
[Editorial change: IAC Supplement 12/29/10]

199—4.7(17A) Agency consideration. Upon request by petitioner, the utilities board must schedule a brief and informal meeting between the original petitioner, all intervenors, and the utilities board, a member of the utilities board, or a member of the staff of the utilities board to discuss the questions raised. The utilities board may solicit comments from any person on the questions raised. Also, comments on the questions raised may be submitted to the utilities board by any person.

199—4.8(17A) Action on petition. Within the time allowed by 1998 Iowa Acts, chapter 1202, section 13(5), after receipt of a petition for a declaratory order, the utilities board or designee shall take action on the petition as required by 1998 Iowa Acts, chapter 1202, section 13(5).

199—4.9(17A) Refusal to issue order.

4.9(1) The utilities board shall not issue a declaratory order where prohibited by 1998 Iowa Acts, chapter 1202, section 13(1), and may refuse to issue a declaratory order on some or all of the questions raised for the following reasons:

1. The question does not substantially comply with the required form.
2. The petition does not contain facts sufficient to demonstrate that the petitioner will be aggrieved or adversely affected by the failure of the utilities board to issue an order.
3. The utilities board does not have jurisdiction over the questions presented in the petition.
4. The questions presented by the petition are also presented in a current rule making, contested case, or other agency or judicial proceeding, that may definitively resolve them.
5. The questions presented by the petition would more properly be resolved in a different type of proceeding or by another body with jurisdiction over the matter.
6. The facts or questions presented in the petition are unclear, overbroad, insufficient, or otherwise inappropriate as a basis upon which to issue an order.
7. There is no need to issue an order because the questions raised in the petition have been settled due to a change in circumstances.
8. The petition is not based upon facts calculated to aid in the planning of future conduct but is, instead, based solely upon prior conduct in an effort to establish the effect of that conduct or to challenge an agency decision already made.
9. The petition requests a declaratory order that would necessarily determine the legal rights, duties, or responsibilities of other persons who have not joined in the petition, intervened separately,

or filed a similar petition and whose position on the questions presented may fairly be presumed to be adverse to that of the petitioner.

10. The petitioner requests the utilities board to determine whether a statute is unconstitutional on its face.

4.9(2) A refusal to issue a declaratory order must indicate the specific grounds for the refusal and constitutes final utilities board action on the petition.

4.9(3) Refusal to issue a declaratory order pursuant to this provision does not preclude the filing of a new petition that seeks to eliminate the grounds for the refusal to issue an order.

199—4.10(17A) Contents of declaratory order—effective date. In addition to the order itself, a declaratory order must contain the date of its issuance, the name of the petitioner and all intervenors, the specific statutes, rules, policies, decisions, or orders involved, the particular facts upon which it is based, and the reasons for its conclusions.

A declaratory order is effective on the date of issuance.

199—4.11(17A) Copies of orders. A copy of all orders issued in response to a petition for a declaratory order shall be mailed promptly to the original petitioner and all intervenors.

199—4.12(17A) Effect of a declaratory order. A declaratory order has the same status and binding effect as a final order issued in a contested case proceeding. It is binding on the utilities board, the petitioner, and any intervenors who consent to be bound and is applicable only in circumstances where the relevant facts and the law involved are indistinguishable from those on which the order was based. As to all other persons, a declaratory order serves only as precedent and is not binding on the utilities board. The issuance of a declaratory order constitutes final agency action on the petition.

These rules are intended to implement 1998 Iowa Acts, chapter 1202, section 13, and Iowa Code section 476.1.

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CHAPTER 6
COMPLAINT PROCEDURES

[Previously ch 1, renumbered 10/20/75 Supp.]
[Prior to 10/8/86, Commerce Commission[250]]

199—6.1(476) Inquiry. Any person may seek assistance from the Iowa utilities board by appearing in person or placing a telephone call to the Consumer Services Section, Iowa Utilities Board, 1375 E. Court Avenue, Room 69, Des Moines, Iowa, (515)725-7321 or toll-free (877)565-4450. Consumer services may advise the person of the application of the rules, inform the person of utility complaint procedures and advise of written complaint procedures before the board. However, the complaint procedures set forth below are available only after a written complaint is filed.
[Editorial change: IAC Supplement 12/29/10]

199—6.2(476) Complaint. Any person or body politic may file a written complaint requesting a determination of the reasonableness of rates, charges, schedules, service, regulations or anything done or not done by a public utility subject to service or rate regulation by the board. Assistance may be requested in the following manner.

6.2(1) *Information to be filed.* Any person may, by filing a written complaint, request the board to determine whether the utility's charges, practices, facilities or services are in compliance with applicable statutes and rules established by the board, or by the utility in its tariff, and lawfully issued board orders. A written complaint may be filed by facsimile or electronic mail. If there is any question about the authenticity of the complaint, the complainant may be required to file a letter verifying the written complaint. The board may initiate a complaint on its own motion. The complaint should include:

a. The name of the utility, any utility personnel known or believed to be familiar with the facts stated in the letter and the location of the office of the utility where the complaint was originally made and processed.

b. The name of the complainant. If the complaint is being filed on behalf of a person other than the complainant, an affidavit from the person injured by the practice about which the complaint is made should be included stating that the complaint has been received and is believed to be true and accurate to the best of the knowledge of the injured person. A complaint filed by an organization on behalf of its members shall include an affidavit signed by an officer of the organization.

c. The address of the premises where the service or billing problems occurred and, if known, the telephone number and the account number. If the complainant resides at a different address, the complaint should also state where a response to the complaint is to be mailed. The complainant may also provide a telephone number where the complainant can be reached during the day.

d. The nature of the complaint, and efforts made to resolve the matter. Documents—e.g., bills or correspondence—should be included if they will add to the board's understanding of the utility practice about which the complaint is made. If known, references to statutes or rules believed to govern the outcome of the complaint should be included.

e. A proposal for resolving the complaint. The proposal should refer to any known statutes or rules authorizing the remedy request.

6.2(2) *Request for additional information.* If the staff determines that additional information is needed in order to resolve the complaint, the complainant will be notified that specified additional information should be filed. If the requested additional information is not provided within 20 days, the complaint may be dismissed. Dismissal of the complaint on this basis does not prevent the complainant from filing in the future a complaint that includes the requested information.

199—6.3(476) Processing the complaint. When the board receives a complaint that includes necessary information outlined in rule 199—6.2(476), the following complaint procedures will be followed:

6.3(1) The complaint letter and any supplemental information filed by the complainant will be forwarded to the public utility.

6.3(2) A copy of the complaint and any supplemental information will be forwarded by the staff to the consumer advocate.

6.3(3) The utility shall, within 20 days of the date on which the complaint is forwarded to the utility by the board, file a response to the complaint with the board and shall at the same time send a copy of its response to the complainant and the consumer advocate. The utility shall specifically address each allegation made by the complainant and recite any supporting facts, statutes, rules, or tariff provisions supporting its response. The utility shall enclose copies of all related letters, records, or other documents not supplied by the complainant, and all records concerning the complainant that are not confidential or privileged. In cases involving confidential or privileged records, the response shall advise of the records' existence.

199—6.4(476) Proposed resolution.

6.4(1) When the utility response is received, the staff may request from any party any additional information deemed necessary to resolve the complaint. When satisfied that all necessary information has been gathered, the staff will respond by letter to the complainant with a copy to the utility and consumer advocate acknowledging resolution of the complaint or proposing an appropriate resolution of the complaint.

6.4(2) If the staff determines that the action required by the proposed resolution has not been carried out, or new facts arise, the record may be reopened by issuing notice to the parties of further investigation.

199—6.5(476) Initiating formal complaint proceedings.

6.5(1) If the consumer advocate, complainant, or the public utility is dissatisfied with the proposed resolution, a request for formal complaint proceedings may be made. Parties will be informed of their right to request formal proceedings. A request for civil penalties, in accordance with Iowa Administrative Code 199—Chapter 8, may also be filed at this time. Failure to file a request for civil penalties at this time does not preclude a party from requesting civil penalties at a later date during formal proceedings. If no request for formal proceedings is made within 14 days after issuance of the proposed resolution or the specified date of utility action, the proposed resolution will be deemed binding on all parties. The board may initiate formal proceedings and seek civil penalties at any time on its own motion.

6.5(2) The request for formal complaint proceedings shall be filed within 14 days after issuance of the proposed resolution or the specified date of utility action, whichever is later. The request shall be considered as filed on the date of the United States Postal Service postmark, the date personal service is made, or the date received and accepted in the board's records and information center. The request shall be in writing and must be delivered by United States Postal Service, other delivery service, personal service, or through the board's electronic filing system pursuant to 199—Chapter 14. The request shall include the file number (C-XX-XXX or C-XXXX-XXXX) marked on the proposed resolution. It shall explain why the proposed resolution should be modified or rejected and propose an alternate resolution, including any temporary relief desired. Copies of the request shall be mailed to the consumer advocate and the parties.

6.5(3) Upon receipt of a request for formal complaint proceedings, the board shall consider whether formal complaint proceedings should be initiated and issue an order. If the board denies formal complaint proceedings, a party may file a petition for judicial review either in the Polk County district court or in the district court for the county in which the party resides or has its principal place of business pursuant to Iowa Code section 17A.19. If formal complaint proceedings are initiated, an order will be issued docketing the case as a formal complaint and granting or denying, in whole or in part, any temporary relief requested.

199—6.6(476) Applicable procedures. When the complaint is docketed as a formal proceeding, the procedures set forth in 199—Chapter 7 of these rules will apply.

199—6.7(476) Record. The written complaint and all supplemental information shall be made part of the record in the formal complaint proceeding.

199—6.8(476) Special procedures for complaints alleging unauthorized changes in telecommunications services. Notwithstanding the deregulation of a communications service or facility pursuant to Iowa Code section 476.1D, complaints alleging an unauthorized change in telecommunications service (see rule 199—22.23(476)) will be processed pursuant to the rules set forth in this chapter with the following additional or substituted procedures:

6.8(1) Upon receipt of the complaint and with the customer's acknowledgment, a copy of the complaint or a notification of receipt of a telephone, or other oral, complaint will be forwarded to the executing service provider and the preferred service provider as a request for a change in the customer's service to the customer's preferred service provider, unless the service has already been changed to the preferred service provider.

6.8(2) The complaint or notification of receipt of a telephone, or other oral, complaint will also be forwarded to the alleged unauthorized service provider. That entity shall file a response to the complaint within ten days of the date the complaint or notification of receipt of a telephone, or other oral, complaint was forwarded. The response must include proof of verification of the customer's authorization for a change in service or a statement that the unauthorized service provider does not have such proof of verification.

6.8(3) If the alleged unauthorized service provider includes with its response alleged proof of verification of the customer's authorization for a change in service, then the response will be forwarded to the customer. The customer will have ten days to challenge the verification or otherwise reply to the service provider's response.

6.8(4) As a part of the informal complaint proceedings, board staff may issue a proposed resolution to determine the potential liability, including assessment of damages, for unauthorized changes in service among the customer, the previous service provider, the executing service provider, and the submitting service provider, and any other interested person. In the event of a soft slam (as defined in 199 IAC 22.23(1)*"j"*), board staff may also propose joint and several liability between the reseller and the facilities-based service provider. In all cases, the proposed resolution shall allocate responsibility among the interested persons on the basis of their relative responsibility for the events that are the subject matter of the complaint. For purposes of this rule and in the absence of unusual circumstances, the term "damages" means charges directly relating to the telecommunications services provided to the customer that have appeared or may appear on the customer's bill. The term "damages" does not include incidental, consequential, or punitive damages.

6.8(5) If the complainant, the service provider, consumer advocate, or any other interested person directly affected by the proposed decision is dissatisfied with the proposed resolution, a request for formal complaint proceedings may be filed. A request for formal complaint proceedings will be processed by the board pursuant to 199 IAC 6.5(476) et seq.

If no request for formal complaint proceedings is received by the board within 14 days after issuance of the proposed resolution, the proposed resolution will be deemed binding upon all persons notified of the informal proceedings and affected by the proposed resolution. Notwithstanding the binding nature of any proposed resolution as to the affected persons, the board may at any time and on its own motion initiate formal proceedings which may alter the allocation of liability.

6.8(6) No entity shall commence any actions to re-bill, directly bill, or otherwise collect any disputed charges for a change in service until after board action on the complaint is final. If final board action finds that the change in service was unauthorized and determines the customer should pay some amount less than the billed amount, the service provider is prohibited from re-billing or taking any other steps whatsoever to collect the difference between the allowed charges and the original charges.

These rules are intended to implement Iowa Code sections 476.2, 476.3 and 546.7 and Iowa Code Supplement section 476.103.

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[1] Effective date of chapter 6 delayed 70 days by administrative rules review committee

CHAPTER 7
PRACTICE AND PROCEDURE

[Previously ch 15, renumbered 10/20/75 Supp.]
[Prior to 10/8/86, Commerce Commission[250]]

199—7.1(17A,474,476) Scope and applicability.

7.1(1) This chapter applies to contested case proceedings, investigations, and other hearings conducted by the board or a presiding officer, unless such proceedings, investigations, and hearings are excepted below, otherwise ordered in any proceeding if reasonably necessary to fulfill the objectives of the proceeding, or are subject to special rules or procedures that may be adopted in specific circumstances. If there are no other applicable procedural rules, this chapter applies to other types of agency action, unless the board or presiding officer orders otherwise. The rules in this chapter regarding the content and format of pleadings, testimony, workpapers, and other supporting documents apply to both paper filings and electronic filings made pursuant to 199—Chapter 14. The rules in this chapter regarding filing, service, and number of copies required apply to paper filings. Where electronic filing is required, documents shall be filed and served according to 199—Chapter 14.

7.1(2) Additional rules applicable only to rate cases, tariff filings, and rate regulation election by rural electric cooperatives are contained in 199—Chapter 26.

7.1(3) With the exception of rules 199—7.22(17A,476) (ex parte communications), 199—7.26(17A,476) (appeals from a proposed decision of a presiding officer), and 199—7.27(17A,476) (rehearing and reconsideration), none of these procedures shall apply to electric transmission line hearings under Iowa Code chapter 478 and 199—Chapter 11 or to pipeline or underground gas storage hearings under Iowa Code chapter 479 or 479B and 199—Chapters 10 and 13. Procedural rules applicable to these proceedings are found in the respective chapters.

7.1(4) Notice of inquiry dockets. The board may issue a notice of inquiry and establish a docket through which the inquiry can be processed. The procedural rules in this chapter shall not apply to these dockets. Instead, the procedures for a notice of inquiry docket shall be specified in the initiating order and shall be subject to change by subsequent order or ruling by the board or the assigned inquiry docket manager. The procedures may include some or all of these procedural rules.

7.1(5) Reorganizations. Procedural rules applicable to reorganizations are included in 199—32.9(476). In the event the requirements in 199—32.9(476) conflict with the requirements in this chapter, the 199—32.9(476) requirements are controlling.

7.1(6) Discontinuance of service incident to utility property transfer.

a. Scope. This rule applies to discontinuance of utility service pursuant to Iowa Code section 476.20(1), which includes the termination or transfer of the right and duty to provide utility service to a community or part of a community incident to the transfer, by sale or otherwise, except a stock transfer incident to corporate reorganization. This rule does not limit rights or obligations created by other applicable statutes or rules including, but not limited to, the rights and obligations created by Iowa Code sections 476.22 to 476.26. Additional rules applicable to discontinuance of service by local exchange utilities and interexchange utilities are contained at rule 199—22.16(476). Discontinuance of service to individual customers is addressed in rules 199—19.4(476), 199—20.4(476), 199—21.4(476), and 199—22.4(476). Procedures in the event of a sale or transfer of a customer base by a telecommunications carrier are contained in 199—paragraph 22.23(2)*"e."*

b. Application. A public utility shall obtain board approval prior to discontinuance of utility service. The public utility shall file an application for permission to discontinue service that includes a summary of the relevant facts and the grounds upon which the application should be granted. When the discontinuance of service is incident to the transfer of utility property, the transferor utility and the transferee shall file a joint application.

c. Approval. Within 30 days after an application is filed, the board shall approve the application or docket the application for further investigation. Failure to act on the application within 30 days will be deemed approval of the application.

d. Contested cases. Contested cases under paragraph *"c"* shall be completed within four months after date of docketing.

e. Criteria. The application will be granted if the board finds the utility service is no longer necessary, or if the board finds the transferee is ready, willing, and able to provide comparable utility service.

7.1(7) The purpose of these rules is to facilitate the transaction of business before the board and to promote the just resolution of controversies. Consistent with this purpose, the application of any of these rules, unless otherwise required by law, may be waived by the board or presiding officer pursuant to 199—1.3(17A,474,476).

7.1(8) Authority to issue procedural orders in contested case proceedings, investigations, hearings, and all other dockets and matters before the board when a majority of the board is not available due to emergency, or for the efficient and reasonable conduct of proceedings, is granted to a single board member. If no member of the board is available to issue a procedural order due to emergency, or for the efficient and reasonable conduct of proceedings, the procedural order may be issued by an administrative law judge employed by the board. If an administrative law judge is not available to issue a procedural order due to an emergency, or for the efficient and reasonable conduct of proceedings, a procedural order may be issued by the executive secretary or general counsel of the board.

Procedural orders under this subrule shall be issued only upon the showing of good cause and when the prejudice to a nonmoving party is not great. The procedural order under this subrule shall state that it is issued pursuant to the delegation authority established in 199 IAC 7.1(8) and that the procedural order so issued is subject to review by the board upon its own motion or upon motion by any party or other interested person.

199—7.2(17A,476) Definitions. Except where otherwise specifically defined by law:

"Board" means the Iowa utilities board or a majority thereof.

"Complainants" are persons who complain to the board of any act or thing done or omitted to be done in violation, or claimed to be in violation, of any provision of Iowa Code chapters 476 through 479B, or of any order or rule of the board.

"Consumer advocate" means the consumer advocate referred to in Iowa Code chapter 475A.

"Contested case" means a proceeding defined by Iowa Code section 17A.2(5) and includes any matter defined as a "no factual dispute" contested case under Iowa Code section 17A.10A.

"Data request" means a discovery procedure in which the requesting party asks another person for specified information or requests the production of documents.

"Expedited proceeding" means a proceeding before the board in which a statutory or other provision of law requires the board to render a decision in the proceeding in six months or less.

"Filed" means received at the office of the board in a manner and form in compliance with the board's filing requirements.

"Intervenor" means any person who, upon written petition, is permitted to intervene in a specific proceeding before the board.

"Issuance" means the date written on the order unless another date is specified in the order.

"Parties" include, but are not limited to, complainants, petitioners, applicants, respondents, and intervenors.

"Party" means each person named or admitted as a party.

"Person" means as defined in Iowa Code section 4.1(20) and includes individuals and all forms of legal entities.

"Petitioner" or *"applicant"* means any party who, by written petition, application, or other filing, applies for or seeks relief from the board.

"Presiding officer" means one board member, the administrative law judge, or another person so designated by the board for the purposes of a particular proceeding.

"Proposed decision" means the presiding officer's recommended findings of fact, conclusions of law, decision, and order in a contested case that has been assigned by the board to the presiding officer.

"Respondent" means any person against whom a complaint or petition is filed, or who by reason of interest or possible interest in the subject matter of a petition or application or the relief sought therein is made a respondent, or to whom an order is directed by the board initiating a proceeding.

"Service" means service by first-class mail pursuant to subrule 7.4(6), unless otherwise specified.

199—7.3(17A,476) Presiding officers. Presiding officers may be designated by the board to preside over contested cases and conduct hearings and shall have the following authority, unless otherwise ordered by the board:

1. To regulate the course of hearings;
2. To administer oaths and affirmations;
3. To rule upon the admissibility of evidence and offers of proof;
4. To take or cause depositions to be taken;
5. To dispose of procedural matters, discovery disputes, motions to dismiss, and other motions which may involve final determination of proceedings, subject to review by the board on its own motion or upon application by any party;
6. To certify any question to the board, in the discretion of the presiding officer or upon direction of the board;
7. To permit and schedule the filing of written briefs;
8. To hold appropriate conferences before, during, or after hearings;
9. To render a proposed decision and order in a contested case proceeding, investigation, or other hearing, subject to review by the board on its own motion or upon application by any party; and
10. To take any other action necessary or appropriate to the discharge of duties vested in the presiding officer, consistent with law and with the rules and orders of the board.

199—7.4(17A,474,476) General information.

7.4(1) *Orders.* All orders will be issued and placed in the board's records and information center. Orders shall be deemed effective upon issuance unless otherwise provided in the order. Parties and members of the public may view orders in the board's records and information center and may also view orders and a daily summary of filings on the board's Web site at http://iub.iowa.gov.

7.4(2) *Communications.*

a. Electronic communications. Pleadings and other documents required to be electronically filed with the board shall be filed within the time limit, if any, for such filing, in accordance with the board's electronic filing rules at 199—Chapter 14. Unless otherwise specifically provided, all electronic communications and documents are officially filed when they are accepted for filing as defined in 199—14.3(17A,476). Persons electronically filing a document with the board must comply with the service requirements in 199—14.16(17A,476).

b. Paper communications. All paper communications to the board or presiding officer shall be addressed to the Executive Secretary, Iowa Utilities Board, 1375 E. Court Avenue, Room 69, Des Moines, Iowa 50319-0069, unless otherwise specifically directed by the board or presiding officer. Pleadings and other documents required to be filed on paper with the board shall be filed within the time limit, if any, for such filing. Unless otherwise specifically provided, all communications and documents are officially filed upon receipt by the executive secretary in a form that complies with the board's filing requirements. Documents filed with the board shall comply with the requirements in 199—subrule 2.1(3). Persons filing a document with the board must comply with the service requirements in subrule 7.4(6) at the time the document is filed with the board.

c. The board may order that filings be submitted electronically in proceedings in which the electronic filing requirement in 199—14.2(17A,476) does not apply. Such filings shall be made pursuant to instructions in 199—Chapter 14 and the board's published standards for electronic information or as delineated in the board order or other official statement requiring those filings.

7.4(3) *Reference to docket number.* All filings made in any proceeding after the proceeding has been docketed by the board shall include on the first page a reference to the applicable docket number(s).

7.4(4) *Number of copies for paper filings.*

a. An original and ten copies are required for most initial filings in a docket made with the board. There are some exceptions, which are listed below. The board or presiding officer may request additional copies.

A = Annual Report (rate-regulated 2 copies, non-rate-regulated 1 copy)
C = Complaints filed pursuant to 199—6.2(476) (original)
CCF = Customer Contribution Fund (original + 1 copy)
E = Electric Franchise or Certificate (original + 3 copies)
EAC = Energy Adjustment Clause (original + 3 copies)
EDR = Electric Delivery Reliability (original + 3 copies)
ES = Extended Area Services (original + 2 copies)
GCU = Generating Certificate Utility (original + 20 copies)
H = Accident (original + 1 copy)
HLP = Hazardous Liquid Pipeline (original + 2 copies)
NIA = Negotiated Interconnection Agreement (original + 3 copies)
P = Pipeline Permit (original + 2 copies)
PGA = Purchased Gas Adjustment (original + 3 copies)
R = Reports-Outages (original + 1 copy)
RFU = Refund Filing Utility (original + 4 copies)
RN = Rate Notification (original + 3 copies)
TF = Tariff Filing (original + 4 copies)

b. Unless otherwise ordered or specified in this rule, parties must either file an original and ten copies or make an electronic filing pursuant to 199—Chapter 14 of all filings including, but not limited to, pleadings and answers (rule 199—7.9(17A,476)), prefiled testimony and exhibits (rule 199—7.10(17A,476)), motions (rule 199—7.12(17A,476)), petitions to intervene and responses (rule 199—7.13(17A,476)), proposals for settlement and responses (rule 199—7.18(17A,476)), stipulations (rule 199—7.19(17A,476)), withdrawals (rule 199—7.21(17A,476)), briefs (subrule 7.23(8)), motions to vacate (subrule 7.23(11)), motions to reopen (rule 199—7.24(17A,476)), interlocutory appeals (rule 199—7.25(17A,476)), appeals from proposed decisions of the presiding officers and responses (rule 199—7.26(17A,476)), applications for rehearing and responses (rule 199—7.27(17A,476)), and requests for stay and responses (rule 199—7.28(17A,476)).

c. When separate dockets are consolidated into a single case, parties shall file one extra copy for each consolidated docket, in addition to the original and the normally required number of copies. For example, if three separate dockets are consolidated into a single case, parties must file an original plus two copies plus the normally required number of copies of each document.

d. Rule 199—7.23(17A,476) contains requirements regarding the required number of copies for evidence introduced at hearing and for briefs. Subrule 7.10(5) contains requirements regarding the required number of copies for workpapers and supporting documents.

e. 199—Chapter 26 contains additional requirements regarding the number of copies required to be filed in rate and tariff proceedings.

7.4(5) *Defective filings.* Only applications, pleadings, documents, testimony, and other submissions that conform to the requirements of an applicable rule, statute, or order of the board or presiding officer will be accepted for filing. Applications, pleadings, documents, testimony, and other submissions that fail to substantially conform with applicable requirements will be considered defective and may be rejected unless waiver of the relevant requirement has been granted by the board or presiding officer prior to filing. The board or presiding officer may reject a filing even though board employees have file-stamped or otherwise acknowledged receipt of the filing. If a filing is defective due only to the number of copies filed, the board's records and information center staff may correct the shortage of copies with the permission of the filing party and the filing party's agreement to cover all costs of reproduction.

7.4(6) *Service of documents.*

a. Method of service.

(1) Paper service. In situations where service of a paper document is permitted or required, and unless otherwise specified by the board or presiding officer or otherwise agreed to by the parties, documents that are required to be served in a proceeding may be served by first-class mail or overnight delivery, properly addressed with postage prepaid, or by delivery in person. In expedited proceedings, if service is made by first-class mail instead of by overnight delivery or personal service, the sending party must supplement service by sending a copy by electronic mail or facsimile if an electronic mail address or facsimile number has been provided by the receiving party. When a document is served, the party effecting service shall file with the board proof of service in substantially the form prescribed in 199—subrule 2.2(16) or an admission of service by the party served or the party's attorney. The proof of service shall be attached to a copy of the document served. When service is made by the board, the board will attach a service list with a certificate of service signed by the person serving the document to each copy of the document served.

(2) Electronic service. The board's rule regarding electronic service is at 199—14.16(17A,476).

b. Date of service.

(1) Paper service. Unless otherwise ordered by the board or presiding officer, the date of service shall be the day when the document served is deposited in the United States mail or overnight delivery, is delivered in person, or otherwise as the parties may agree. Although service is effective, the document is not deemed filed with the board until it is received by the board pursuant to subrule 7.4(2).

(2) Electronic service. The board's rule regarding the date of electronic service is at 199—14.16(17A,476).

c. Parties entitled to service.

(1) Paper service. A party or other person filing a notice, motion, pleading, or other paper document in any proceeding shall contemporaneously serve the document on all other parties.

(2) Electronic service. The board's rule regarding electronic service is at 199—14.16(17A,476).

(3) Service of documents containing confidential information. Parties shall serve documents containing confidential information pursuant to a confidentiality agreement executed by the parties, if any. If the parties are unable to agree on a confidentiality agreement, they may ask the board or presiding officer to issue an appropriate order.

(4) Service on consumer advocate. A party formally filing any paper document or any other material on paper with the board shall serve three copies of the document or material on the consumer advocate at the same time as the filing is made with the board and by the same delivery method used for filing with the board. "Formal filings" include, but are not limited to, all documents that are filed in a docketed proceeding or that request initiation of a docketed proceeding. The address of the consumer advocate is Office of Consumer Advocate, 1375 E. Court Avenue, Room 63, Des Moines, Iowa 50319-0063.

d. Service upon attorneys. When a party has appeared by attorney, service upon the attorney shall be deemed proper service upon the party.

7.4(7) *Written appearance.* Each party to a proceeding shall file a separate written appearance, substantially conforming to the form set forth in 199—subrule 2.2(15), identifying one person upon whom the board may serve all orders, correspondence, or other documents. If a party has previously designated a person to be served on the party's behalf in all matters, filing the appearance will not change this designation, unless the party directs that the designated person be changed in the appearance. If a party files an application, petition, or other initial pleading, or an answer or other responsive pleading, containing the information that would otherwise be required in an appearance, the filing of a separate appearance is not required. The appearance may be filed with the party's initial filing in the proceeding or may be filed after the proceeding has been docketed.

7.4(8) *Representation by attorney-at-law.*

a. Any party to a proceeding before the board or a presiding officer may appear and be heard through a licensed attorney-at-law. If the attorney is not licensed by the state of Iowa, permission to appear must be granted by the board or presiding officer. A verified statement that contains the attorney's agreement to submit to and comply with the Iowa Code of Professional Responsibility for Lawyers must

be filed with the board and the written appearance of a resident attorney must be provided for service pursuant to Iowa Admission to the Bar rule 31.14(2).

b. A corporation or association may appear and present evidence by an officer or employee. However, only licensed attorneys shall represent a party before the board or a presiding officer in any matter involving the exercise of legal skill or knowledge, except with the consent of the board or presiding officer. All persons appearing in proceedings before the board or a presiding officer shall conform to the standard of ethical conduct required of attorneys before the courts of Iowa.

7.4(9) *Cross reference to public documents, confidential filings, and electronic filings.* The board's rule regarding public documents and confidential filings is at 199—1.9(22). The board's rule regarding electronic filing of documents containing confidential material is at 199—14.12(17A,476).

7.4(10) *Expedited proceedings.*

a. If a person claims that a statutory or other provision of law requires the board to render a decision in a contested case in six months or less, the person shall include the phrase "Expedited Proceedings Required" in the caption of the first pleading filed by the person in the proceeding. If the phrase is not so included in the caption, the board or presiding officer may find and order that the proceeding did not commence for purposes of the required time for decision until the date on which the first pleading containing the required phrase is filed or such other date that the board or presiding officer finds is just and reasonable under the circumstances.

b. If a person claims that a statutory or other provision of law requires the board to render a decision in a contested case in six months or less, the person shall state the basis for the claim in the first pleading in which the claim is made.

c. Shortened time limits applicable to expedited proceedings are contained in rules 199—7.9(17A,476) (pleadings and answers), 199—7.12(17A,476) (motions), 199—7.13(17A,476) (intervention), 199—7.15(17A,476) (discovery), and 199—7.26(17A,476) (appeals from proposed decisions). An additional service requirement applicable to expedited proceedings is contained in subrule 7.4(6) (service of documents).

d. A party may file a motion that proceedings be expedited even though such treatment is not required by statute or other provision of law. Such voluntary expedited treatment may be granted at the board's or presiding officer's discretion in appropriate circumstances considering the needs of the parties and the interests of justice. In these voluntary expedited proceedings, the board or presiding officer may shorten the filing dates or other procedures established in this chapter. The shortened time limits and additional service requirement applicable to expedited proceedings established in this chapter and listed in paragraph 7.4(10)*"c"* do not apply to voluntary expedited proceedings under this paragraph unless ordered by the board or presiding officer.

[Editorial change: IAC Supplement 12/29/10]

199—7.5(17A,476) Time requirements.

7.5(1) Time shall be computed as provided in Iowa Code subsection 4.1(34).

7.5(2) In response to a request or on its own motion, for good cause, the board or presiding officer may extend or shorten the time to take any action, except as precluded by statute.

199—7.6(17A,476) Telephone proceedings. The board or presiding officer may hold proceedings by telephone conference call in which all parties have an opportunity to participate. The board or presiding officer will determine the location of the parties and witnesses for telephone hearings. The convenience of the witnesses or parties, as well as the nature of the case, will be considered when locations are determined.

199—7.7(17A,476) Electronic information. Filing of electronic information shall comply with the board's rules on electronic filing at 199—Chapter 14 and the board's published standards for electronic information, available on the board's Web site at http://iub.iowa.gov or from the board's records and information center.

[Editorial change: IAC Supplement 12/29/10]

199—7.8(17A,476) Delivery of notice of hearing. When the board or presiding officer issues an order containing a notice of hearing, delivery of the order will be by first-class mail or by electronic notice through the electronic filing system unless otherwise ordered.

199—7.9(17A,476) Pleadings and answers.

7.9(1) *Pleadings.* Pleadings may be required by statute, rule, or order.

7.9(2) *Answers.*

a. Unless otherwise ordered by the board or presiding officer, answers to complaints, petitions, applications, or other pleadings shall be filed with the board within 20 days after the day on which the pleading being answered was served upon the respondent or other party. However, when a statute or other provision of law requires the board to issue a decision in the case in six months or less, the answer shall be filed with the board within 10 days of service of the pleading being answered, unless otherwise ordered by the board or presiding officer.

b. Each answer must specifically admit, deny, or otherwise answer all material allegations of the pleadings and also briefly set forth the affirmative grounds relied upon to support each answer.

c. Any party who deems the complaint, petition, application, or other pleading insufficient to show a breach of legal duty or grounds for relief may move to dismiss instead of, or in addition to, answering.

d. A party may apply for a more definitive and detailed statement instead of, or in addition to, answering, if appropriate.

e. An answer shall substantially comply with the form prescribed in 199—subrule 2.2(8).

7.9(3) *Amendments to pleadings.* Amendments to pleadings may be allowed upon proper motion at any time during the pendency of the proceeding upon such terms as are just and reasonable.

199—7.10(17A,476) Prefiled testimony and exhibits.

7.10(1) The board or presiding officer may order the parties to file prefiled testimony and exhibits prior to the hearing. The use of prefiled testimony is the standard method for providing testimony in board contested case proceedings. If ordered to do so, parties must file the prefiled testimony and exhibits according to the schedule in the procedural order.

7.10(2) Prefiled testimony contains all statements that a witness intends to give under oath at the hearing, set forth in question and answer form. If possible, each line should be separately numbered. When a witness who has submitted prefiled testimony takes the stand, the witness does not ordinarily repeat the written testimony or give new testimony. Instead, the witness is cross-examined by the other parties concerning the statements already made in writing. However, the witness may be permitted to correct or update prefiled testimony on the stand and, in appropriate circumstances and with the approval of the board or presiding officer, may give a summary of the prefiled testimony. If the witness has more than three corrections to make, then the corrections should be filed in written form prior to the hearing.

7.10(3) Parties who wish to present a witness or other evidence in a proceeding shall comply with the board's or presiding officer's order concerning prefiled testimony and documentary evidence, unless otherwise ordered, or unless otherwise provided by statute or other provision of law.

7.10(4) Prefiled testimony and exhibits must be accompanied by an affidavit in substantially the following form: "I, [person's name], being first duly sworn on oath, state that I am the same [person's name] identified in the testimony being filed with this affidavit, that I have caused the testimony [and exhibits] to be prepared and am familiar with its contents, and that the testimony [and exhibits] is true and correct to the best of my knowledge and belief as of the date of this affidavit."

7.10(5) Prefiled testimony and exhibits submitted on paper shall include, where applicable:

a. All supporting workpapers.

(1) Unless otherwise ordered by the board or presiding officer, electronic workpapers in native electronic formats that comply with the board's standards for electronic information, which are available on the board's Web site or from the board's records and information center, shall be provided. Noncompliant electronic workpapers shall be provided as a hard copy with a brief description of software and hardware requirements. Noncompliant electronic copies shall be provided upon request by any party, the board, or the presiding officer.

(2) All other workpapers and hard-copy printouts of electronic files shall be clearly tabbed and indexed, and pages shall be numbered. Each section shall include a brief description of the sources of inputs, operations contained therein, and where outputs are next used.

(3) Workpapers' underlying analyses and data presented in exhibits shall be explicitly referenced within the exhibit, including the name and other identifiers (e.g., cell coordinates) for electronic workpapers, and volume, tab, and page numbers for other workpapers.

(4) The source of any number used in a workpaper that was not generated by that workpaper shall be identified.

b. The derivation or source of all numbers used in either testimony or exhibits that were not generated by workpapers.

c. Copies of any specific studies or financial literature relied upon or complete citations for them if publicly available.

d. Electronic copies, in native electronic format, of all computer-generated exhibits that comply with the board's standards for electronic information, which are available on the board's Web site or in the board's records and information center. Noncompliant electronic computer-generated exhibits shall be provided as a hard copy with a brief description of software and hardware requirements. Noncompliant electronic copies shall be provided upon request by any party, the board, or the presiding officer.

e. Unless otherwise ordered by the board or presiding officer, the following number of copies shall be filed:

(1) Electronic workpapers—two copies and two hard-copy printouts.

(2) Other workpapers—five copies.

(3) Specific studies or financial literature—two copies.

(4) Computer-generated exhibits—two copies.

7.10(6) Any prefiled testimony, including workpapers and exhibits, that is subject to the electronic filing requirement shall comply with the board's standards for electronic information, which are available on the board's Web site or in the board's records and information center, and the electronic filing rules in 199—Chapter 14.

7.10(7) If a party has filed part or all of prefiled testimony and exhibits as confidential pursuant to 199—1.9(22), and then later withdraws the claim of confidentiality for part or all of the testimony and exhibits, or if the board denies the request to hold the testimony and exhibits confidential, the party must refile the testimony and exhibits without the confidential stamp on each page.

199—7.11(17A,476) Documentary evidence in books and materials. When documentary evidence being offered is contained in a book, report, or other document, the offering party should ordinarily file only the material, relevant portions in an exhibit or read them into the record. If a party offers the entire book, report, or other document containing the evidence being offered, the party shall plainly designate the evidence so offered.

199—7.12(17A,476) Motions. Motions, unless made during hearing, shall be in writing, state the grounds for relief, and state the relief or order sought. Motions based on matters that do not appear of record shall be supported by affidavit. Motions filed on paper shall substantially comply with the form prescribed in 199—subrule 2.2(14) and shall be filed and served pursuant to rule 199—7.4(17A,476). Motions filed electronically shall substantially comply with the form prescribed in 199—subrule 2.2(14)and shall be filed according to 199—Chapter 14. Any party may file a written response to a motion no later than 14 days from the date the motion is filed, unless the time period is extended or shortened by the board or presiding officer. When a statutory or other provision of law requires the board to issue a decision in the case in six months or less, written responses to a motion must be filed within 7 days of the date the motion is filed, unless otherwise ordered by the board or presiding officer. Failure to file a timely response may be deemed a waiver of objection to the motion. Requirements regarding motions related to discovery are contained at 199—subrules 7.15(4) and 7.15(5).

199—7.13(17A,476) Intervention.

7.13(1) Petition. Unless otherwise ordered by the board or presiding officer, a request to intervene in a proceeding shall be by petition to intervene filed no later than 20 days following the order setting a procedural schedule. However, when a statutory or other provision of law requires the board to issue a decision in the case in six months or less, the petition to intervene must be filed no later than 10 days following the order setting a procedural schedule, unless otherwise ordered by the board or presiding officer. A petition to intervene shall substantially comply with the form prescribed in 199—subrule 2.2(10).

7.13(2) Response. Any party may file a response within seven days of service of the petition to intervene unless the time period is extended or shortened by the board or presiding officer.

7.13(3) Grounds for intervention. Any person having an interest in the subject matter of a proceeding may be permitted to intervene at the discretion of the board or presiding officer. In determining whether to grant intervention, the board or presiding officer shall consider:

a. The prospective intervenor's interest in the subject matter of the proceeding;

b. The effect of a decision that may be rendered upon the prospective intervenor's interest;

c. The extent to which the prospective intervenor's interest will be represented by other parties;

d. The availability of other means by which the prospective intervenor's interest may be protected;

e. The extent to which the prospective intervenor's participation may reasonably be expected to assist in the development of a sound record through presentation of relevant evidence and argument; and

f. Any other relevant factors.

7.13(4) In determining the extent to which the prospective intervenor's interest will be represented by other parties, the consumer advocate's role of representing the public interest shall not be interpreted as representing every potential interest in a proceeding.

7.13(5) The board or presiding officer may limit a person's intervention to particular issues or to a particular stage of the proceeding, or may otherwise condition the intervenor's participation in the proceeding. Leave to intervene shall generally be granted by the board or presiding officer to any person with a cognizable interest in the proceeding.

7.13(6) When two or more intervenors have substantially the same interest, the board or presiding officer, in the board's or presiding officer's discretion, may order consolidation of petitions and briefs and limit the number of attorneys allowed to participate actively in the proceedings to avoid a duplication of effort.

7.13(7) A person granted leave to intervene is a party to the proceeding. However, unless the board or presiding officer rules otherwise for good cause shown, an intervenor shall be bound by any agreement, arrangement, or order previously made or issued in the case.

199—7.14(17A,476) Consolidation and severance.

7.14(1) *Consolidation.* The board or presiding officer may consolidate any or all matters at issue in two or more contested cases. When deciding whether to consolidate, the board or presiding officer shall consider:

a. Whether the matters at issue involve common parties or common questions of fact or law;

b. Whether consolidation is likely to expedite or simplify consideration of the issues involved;

c. Whether consolidation would adversely affect the substantial rights of any of the parties to the proceedings; and

d. Any other relevant factors.

7.14(2) *Severance.* The board or presiding officer may order any contested case or portions thereof severed for good cause.

199—7.15(17A,476) Discovery.

7.15(1) Discovery procedures applicable in civil actions are available to parties in contested cases.

7.15(2) Unless otherwise ordered by the board or presiding officer or agreed to by the parties, data requests or interrogatories served by any party shall either be responded to or objected to, with concisely

stated grounds for relief, within seven days of receipt. When a statutory or other provision of law requires the board to issue a decision in the case in six months or less, this time is reduced to five days.

7.15(3) Unless otherwise ordered by the board or presiding officer, time periods for compliance with all forms of discovery other than those stated in subrule 7.15(2) shall be as provided in the Iowa Rules of Civil Procedure.

7.15(4) Prior to filing any motion related to discovery, parties shall make a good-faith effort to resolve discovery disputes without the involvement of the board or presiding officer.

7.15(5) Any motion related to discovery shall allege that the moving party has made a good-faith attempt to resolve the discovery issues involved with the opposing party. Opposing parties shall be given the opportunity to respond within ten days of the filing of the motion unless the time is shortened by order of the board or presiding officer. When a statutory or other provision of law requires the board to issue a decision in the case in six months or less, this time is reduced to five days. The board or presiding officer may rule on the basis of the written motion and any response, or may order argument or other proceedings on the motion.

199—7.16(17A,476) Subpoenas.

7.16(1) *Issuance.*

a. An agency subpoena shall be issued to a party on request. The request shall be in writing and include the name, address, and telephone number of the requesting party. In the absence of good cause for permitting later action, a request for a subpoena must be received at least seven days before the scheduled hearing. The board will issue subpoenas only on paper, not through the electronic filing system.

b. Except to the extent otherwise provided by law, parties are responsible for service of their own subpoenas and payment of witness fees and mileage expenses. Subpoenas cannot be served electronically through the electronic filing system.

7.16(2) *Motion to quash or modify.* Upon motion, the board or presiding officer may quash or modify a subpoena for any lawful reason.

199—7.17(17A,476) Prehearing conference. An informal conference of parties may be ordered at the discretion of the board or presiding officer or at the request of any party for any appropriate purpose. Any agreement reached at the conference shall be made a part of the record in the manner directed by the board or presiding officer.

199—7.18(17A,476) Settlements. Parties to a contested case may propose to settle all or some of the issues in the case. The board or presiding officer will not approve settlements, whether contested or uncontested, unless the settlement is reasonable in light of the whole record, consistent with law, and in the public interest. Board adoption of a settlement constitutes the final decision of the board on issues addressed in the settlement.

7.18(1) *Proposal of settlements.* Two or more parties may by written motion propose settlements for adoption by the board or presiding officer. The motion shall contain a statement adequate to advise the board or presiding officer and parties not expressly joining the proposal of its scope and of the grounds on which adoption is urged. Parties may propose a settlement for adoption by the board or presiding officer at any time.

7.18(2) *Conference.* After proposal of a settlement that is not supported by all parties, and prior to approval, the settling parties shall convene at least one conference with notice and opportunity to participate provided to all parties for the purpose of discussing the settlement proposal. Written notice of the date, time, and place shall be furnished at least seven days in advance to all parties to the proceeding. Attendance at any settlement conference shall be limited to the parties to a proceeding and their representatives. A party that has been given notice and opportunity to participate in the conference and does not do so shall be deemed to have waived its right to contest a proposed settlement, unless good cause is shown for the failure to participate.

7.18(3) *Comment period.* When a party to a proceeding does not join in a settlement proposed for adoption by the board or presiding officer, the party may file comments contesting all or part of the

settlement with the board. Unless otherwise ordered by the board or presiding officer, the party shall file its comments within 14 days of filing of the motion proposing settlement, and shall serve such comments on all parties to the proceeding at the time of filing. Unless otherwise ordered by the board or presiding officer, parties shall file reply comments within 7 days of filing of the comments.

7.18(4) *Contents of comments.* A party contesting a proposed settlement must specify in its comments the portions of the settlement that it opposes, the legal basis of its opposition, and the factual issues that it contests. Any failure by a party to file comments may, at the board's or presiding officer's discretion, constitute waiver by that party of all objections to the settlement.

7.18(5) *Contested settlements.* If the proposed settlement is contested, in whole or in part, on any material issue of fact by any party, the board or presiding officer may schedule a hearing on the contested issue(s). The board or presiding officer may decline to schedule a hearing where the contested issue of fact is not material or where the contested issue is one of law.

7.18(6) *Unanimous proposed settlement.* In proceedings where all parties join in the proposed settlement, parties may propose a settlement for adoption by the board or presiding officer any time after docketing. Subrules 7.18(2) through 7.18(5) shall not apply to a proposed settlement filed concurrently by all parties to the proceeding.

7.18(7) *Inadmissibility.* Any discussion, admission, concession, or offer to settle, whether oral or written, made during any negotiation on a settlement shall be privileged to the extent provided by law, including, but not limited to, Iowa R. Evid. 5.408.

199—7.19(17A,476) Stipulations. Parties to any proceeding or investigation may, by stipulation filed with the board, agree upon the facts or law or any portion thereof involved in the controversy, subject to approval by the board or presiding officer.

199—7.20(17A,476) Investigations. The availability of discovery pursuant to Iowa Code section 17A.13 or the Iowa Rules of Civil Procedure shall not be construed to limit the investigatory powers of the board, its representatives, or the consumer advocate.

199—7.21(17A,476) Withdrawals. A party requesting a contested case proceeding may, with the permission of the board or presiding officer, withdraw that request at any time prior to the issuance of a proposed or final decision in the case.

199—7.22(17A,476) Ex parte communication. Ex parte communication is prohibited as provided in Iowa Code section 17A.17. Parties or their representatives shall not communicate directly or indirectly with the board or presiding officer in connection with any issue of fact or law in a contested case except upon notice and an opportunity for all parties to participate. The board or presiding officer shall not communicate directly or indirectly with parties or their representatives in connection with any issue of fact or law in a contested case except upon notice and an opportunity for all parties to participate.

199—7.23(17A,476) Hearings.

7.23(1) *Board or presiding officer.* The board or presiding officer presides at the hearing and may rule on motions and issue such orders and rulings as will ensure the orderly conduct of the proceedings. The board or presiding officer shall maintain the decorum of the hearing and may refuse to admit, may set limits on, or may expel from the hearing anyone whose conduct is disorderly.

7.23(2) *Witnesses.* Each witness shall be sworn or affirmed by the board, presiding officer, or the court reporter and be subject to examination and cross-examination. The board or presiding officer may limit questioning in a manner consistent with law. In appropriate circumstances, the board or presiding officer may order that witnesses testify as members of a witness panel.

7.23(3) *Order of presenting evidence.* The board or presiding officer shall determine the order of the presentation of evidence based on applicable law and the interests of efficiency and justice, taking into account the preferences of the parties. Normally, the petitioner shall open the presentation of evidence. In cases where testimony has been prefiled, each witness shall be available for cross-examination on all

testimony prefiled by or on behalf of that witness when the witness takes the stand, either alone or as a member of a witness panel.

7.23(4) *Evidence.*

a. Subject to terms and conditions prescribed by the board or presiding officer, parties have the right to introduce evidence, cross-examine witnesses, and present evidence in rebuttal. Ordinarily, prefiled testimony is used in hearings pursuant to rule 199—7.10(17A,476). Nonsubstantive corrections to prefiled testimony may be made at the beginning of the testimony. However, if more than three corrections need to be made, the sponsoring party shall file corrected prefiled testimony prior to the hearing. The sponsoring party must provide one copy of prefiled testimony and included exhibits to the court reporter.

b. The board or presiding officer shall rule on admissibility of evidence and may, where appropriate, take official notice of facts in accordance with law.

c. Stipulation of facts is encouraged. The board or presiding officer may make a decision based on stipulated facts.

d. Unless previously included with prefiled testimony, the party seeking admission of an exhibit must provide opposing parties with an opportunity to examine the exhibit prior to the ruling on its admissibility. All exhibits admitted into evidence shall be appropriately marked and made part of the evidentiary record. If an exhibit is admitted, unless previously included with prefiled testimony, the sponsoring party must provide at least one copy of the exhibit to each opposing party, one copy for each board member or presiding officer, one copy for the witness (if any), one copy for the court reporter, and two copies for board staff, unless otherwise ordered.

e. Whenever evidence is ruled inadmissible, the party offering that evidence may submit an offer of proof on the record. The party making the offer of proof for excluded oral testimony shall briefly summarize the testimony or, with the permission of the board or presiding officer, present the testimony. The board or presiding officer may require the offering party to file a written statement of the excluded oral testimony. If the excluded evidence consists of a document or exhibit, it shall be marked as part of an offer of proof and inserted in the record. Unless previously included with prefiled testimony, the sponsoring party must provide at least one copy of the document or exhibit to each opposing party, one copy for each board member or presiding officer, one copy for the witness (if any), one copy for the court reporter, and two copies for board staff, unless otherwise ordered.

7.23(5) *Objections.* Any party may object to specific evidence or may request limits on the scope of any examination or cross-examination. All objections shall be timely made on the record and state the grounds relied on. The board or presiding officer may rule on the objection at the time it is made or may reserve a ruling until the written decision.

7.23(6) *Further evidence.* At any stage during or after the hearing, the board or presiding officer may order a party to present additional evidence and may conduct additional proceedings as appropriate.

7.23(7) *Participation at hearings by nonparties.* The board or presiding officer may permit any person to be heard and to examine and cross-examine witnesses at any hearing, but such person shall not be a party to the proceedings unless so designated. The testimony or statement of any person so appearing shall be given under oath and such person shall be subject to cross-examination by parties to the proceeding, unless the board or presiding officer orders otherwise.

7.23(8) *Briefs.*

a. Unless waived by the parties with the consent of the board or presiding officer, the board or presiding officer shall set times for the filing and service of briefs. Unless otherwise ordered by the board or presiding officer, initial briefs shall be filed simultaneously by all parties and reply briefs shall be filed simultaneously.

b. Unless otherwise electronically filed and served pursuant to 199—Chapter 14 or otherwise ordered, parties shall file an original and ten copies of briefs with the board and shall serve two copies of briefs on the other parties pursuant to subrule 7.4(6). Parties may serve one paper copy and one copy by electronic mail on the other parties instead of two paper copies. Three copies of briefs shall be served on the consumer advocate pursuant to subrule 7.4(6).

c. Initial briefs shall contain a concise statement of the case. Arguments based on evidence introduced during the proceeding shall specify the portions of the record where the evidence is found. Initial briefs shall include all arguments the party intends to offer in support of its case and against the record case of the adverse party or parties. Unless otherwise ordered, a reply brief shall be confined to refuting arguments made in the brief of an adverse party. Unless specifically ordered to brief an issue, a party's failure to address an issue by brief shall not be deemed a waiver of that issue and shall not preclude the board or presiding officer from deciding the issue on the basis of evidence appearing in the record.

d. Every brief of more than 20 pages shall contain on its front leaves a table of contents with page references. Each party's initial brief shall not exceed 90 pages and each subsequent brief shall not exceed 40 pages, exclusive of the table of contents, unless otherwise ordered. Such orders may be issued ex parte. A brief that exceeds these page limits shall be deemed a defective filing and may be rejected as provided in subrule 7.4(5).

e. Briefs shall comply with the following requirements.

(1) The size of pages shall be 8½ by 11 inches.

(2) All printed matter must appear in at least 11-point type.

(3) There shall be margins of at least one inch on the top, bottom, right, and left sides of the sheet.

(4) The body of the brief shall be double-spaced.

(5) Footnotes may be single-spaced but shall not exceed one-half page in length.

(6) The printed matter may appear in any pitch, as long as the characters are spaced in a readable manner. Any readable font is acceptable.

(7) Briefs filed electronically shall comply with the requirements in this paragraph and the standards for electronic information available on the board's Web site or in the board's records and information center.

7.23(9) *Oral arguments.* The board or presiding officer may set a time for oral argument at the conclusion of the hearing, or may set a separate date and time for oral argument. The board or presiding officer may set a time limit for argument. Oral argument may be either in addition to or in lieu of briefs. Unless specifically ordered to argue an issue, a party's failure to address an issue in oral argument shall not be deemed a waiver of the issue.

7.23(10) *Record.* The record of the case is maintained in the board's records and information center at the office of the board. Unless held confidential pursuant to 199—1.9(22), parties and members of the public may examine the record and obtain copies of documents other than the transcript. The transcript will be available for public examination, but copying of the transcript may be restricted by the terms of the contract with the court reporting service.

7.23(11) *Default.*

a. If a party fails to appear at a hearing after proper service of notice, or fails to answer or otherwise respond to an appropriate pleading directed to and properly served upon that party, the board or presiding officer may, if no adjournment is granted, enter a default decision or proceed with the hearing and render a decision in the absence of the party.

b. Default decisions or decisions rendered on the merits after a party has failed to appear at a hearing constitute final agency action unless otherwise ordered by the board or presiding officer. However, within 15 days after the date of notification or mailing of the decision, a motion to vacate may be filed with the board. The motion to vacate must state all facts relied on by the moving party that show good cause existed for that party's failure to appear at the hearing or answer or otherwise respond to an appropriate pleading directed to and properly served upon that party. The stated facts must be substantiated by affidavit attached to the motion. Unless otherwise ordered, adverse parties shall have 10 days to respond to a motion to vacate. If the decision is rendered by a presiding officer, the board may review it on the board's own motion within 15 days after the date of notification or mailing of the decision.

c. The time for appeal of a decision for which a timely motion to vacate has been filed is stayed pending a decision on the motion to vacate.

d. Properly substantiated and timely filed motions to vacate shall be granted for good cause shown. The burden of proof as to good cause is on the moving party. "Good cause" for purposes of this rule shall have the same meaning as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

e. A presiding officer's decision denying a motion to vacate is subject to further appeal within the time limit allowed for further appeal of a decision on the merits in the contested case. A presiding officer's decision granting a motion to vacate is subject to interlocutory appeal by the adverse party pursuant to rule 199—7.25(17A,476).

f. If a motion to vacate is granted and no timely interlocutory appeal has been taken, the board or presiding officer shall schedule another hearing and the contested case shall proceed accordingly.

g. A default decision may award any relief consistent with the record in the case. The default decision may provide either that the default decision is to be stayed pending a timely motion to vacate or that the default decision is to take effect immediately, subject to a timely motion to vacate, an appeal pursuant to rule 199—7.26(17A,476), or a request for stay pursuant to rule 199—7.28(17A,476).

199—7.24(17A,476) Reopening record. The board or presiding officer, on the board's or presiding officer's own motion or on the motion of a party, may reopen the record for the reception of further evidence. When the record was made before the board, a motion to reopen the record may be made any time prior to the issuance of a final decision. When the record was made before a presiding officer, a motion to reopen the record shall be made prior to the expiration of the time for appeal from the proposed decision, and the motion shall stay the time for filing an appeal. A motion to reopen the record shall substantially comply with the form prescribed in 199—subrule 2.2(12). Affidavits of witnesses who will present new evidence shall be attached to the motion and shall include an explanation of the competence of the witness to sponsor the evidence and a description of the evidence to be included in the record.

199—7.25(17A,476) Interlocutory appeals. Upon written request of a party or on its own motion, the board may review an interlocutory order of the presiding officer. In determining whether to do so, the board may consider the extent to which granting the interlocutory appeal would expedite final resolution of the case and the extent to which review of that interlocutory order by the board at the time it reviews the proposed decision would provide an adequate remedy. Any request for interlocutory review must be filed within ten days of issuance of the challenged order, but no later than the time for compliance with the order or ten days prior to the date of hearing, whichever is first.

199—7.26(17A,476) Appeals to board from a proposed decision of a presiding officer.

7.26(1) Notification of proposed decision. Notice of the presiding officer's proposed decision and order in a contested case shall be sent through the electronic filing system or by first-class mail if any paper filing requirements apply to the proceeding, on the date the order is issued, to the last-known address of each party. The decision shall normally include "Proposed Decision and Order" in the title and shall normally inform the parties of their right to appeal an adverse decision and the time in which an appeal must be taken.

7.26(2) Appeal from proposed decision. A proposed decision and order of the presiding officer in a contested case shall become the final decision of the board unless, within 15 days after the decision is issued, the board moves to review the decision or a party files an appeal of the decision with the board. The presiding officer may shorten the time for appeal. In determining whether a request for a shortened appeal period should be granted, the presiding officer may consider the needs of the parties for a shortened appeal period, relevant objections of the parties, the relevance of any written objections filed in the case, and whether there are any issues that indicate a need for the 15-day appeal period.

7.26(3) Any adversely affected party may appeal a proposed decision by timely filing a notice of appeal. If the electronic filing requirement applies to the proceeding in which the appeal is taken, the notice of appeal shall be electronically filed unless the appellant has received permission from the board to submit paper filings. If the electronic filing requirement does not apply, the appellant shall file an

original and ten copies of the notice of appeal with the board, provide a copy to the presiding officer, and simultaneously serve a copy of the notice pursuant to subrule 7.4(6) on all parties.

7.26(4) The board shall not consider any claim of error based on evidence which was not introduced before the presiding officer. Newly discovered material evidence must be presented to the presiding officer pursuant to a motion to reopen the record, unless the board orders otherwise.

7.26(5) Contents of notice of appeal. The notice of appeal shall include the following in separately numbered paragraphs supported, where applicable, by controlling statutes and rules.

a. A brief statement of the facts.

b. A brief statement of the history of the proceeding, including the date and a description of any ruling claimed to be erroneous.

c. A statement of each of the issues to be presented for review.

d. A precise description of the error(s) upon which the appeal is based. If a claim of error is based on allegations that the presiding officer failed to correctly interpret the law governing the proceeding, exceeded the authority of a presiding officer, or otherwise failed to act in accordance with law, the appellant shall include a citation to briefs or other documents filed in the proceeding before the presiding officer where the legal points raised in the appeal were discussed. If a claim of error is based on allegations that the presiding officer failed to give adequate consideration to evidence introduced at hearing, the appellant shall include a citation to pages of the transcript or other documents where the evidence appears.

e. A precise statement of the relief requested.

f. A statement as to whether an opportunity to file a brief or make oral argument in support of the appeal is requested and, if an opportunity is sought, a statement explaining the manner in which briefs and arguments presented to the presiding officer are inadequate for purposes of appeal.

g. Certification of service showing the names and addresses of all parties upon whom a copy of the notice of appeal was served.

7.26(6) Responsive filings and cross-appeals. If parties wish to respond to the notice of appeal, or file a cross-appeal, they must file the response or notice of cross-appeal within 14 days after the filing of the notice of appeal, unless otherwise ordered by the board. When a statutory or other provision of law requires the board to issue a decision in the case in less than six months, the response or cross-appeal must be filed within 7 days of filing the notice of appeal.

a. Responses shall specifically respond to each of the substantive paragraphs of the notice of appeal and shall state whether an opportunity to file responsive briefs or to participate in oral argument is requested.

b. Parties who file a cross-appeal must comply with the requirements for filing a notice of appeal contained in this rule, other than the requirement to file notice of the cross-appeal within 15 days after the proposed decision is issued.

7.26(7) Ruling on appeal. After the filing of the last appeal, response, or cross-appeal, the board shall issue an order that may establish a procedural schedule for the appeal or may be the board's final decision on the merits of the appeal.

199—7.27(17A,476) Rehearing and reconsideration.

7.27(1) *Application for rehearing or reconsideration.* Any party to a contested case may file an application for rehearing or reconsideration of the final decision. The application for rehearing or reconsideration shall be filed within 20 days after the final decision in the contested case is issued. This subrule shall not be construed as prohibiting reconsideration of board orders in other than contested cases.

7.27(2) *Contents of application.* Applications for rehearing or reconsideration shall specify the findings of fact and conclusions of law claimed to be erroneous, with a brief statement of the alleged grounds of error. Any application for rehearing or reconsideration asserting that evidence has arisen since the final order was issued as a ground for rehearing or reconsideration shall present the evidence by affidavit that includes an explanation of the competence of the person to sponsor the evidence and a

brief description of the evidence sought to be included. An application shall substantially comply with the form prescribed in 199—subrule 2.2(13).

7.27(3) *Requirements for objections to applications for rehearing or reconsideration.* Notwithstanding the provisions of subrule 7.9(2), an answer or objection to an application for a rehearing or reconsideration must be filed within 14 days of the date the application was filed with the board, unless otherwise ordered by the board. The answer or objection to the application shall substantially comply with the form prescribed in 199—subrule 2.2(8).

199—7.28(17A,476) Stay of agency decision.

7.28(1) Any party to a contested case proceeding may petition the board for a stay or other temporary remedy pending judicial review of the proceeding. The petition shall state the reasons justifying a stay or other temporary remedy and be served on all other parties pursuant to subrule 7.4(6).

7.28(2) In determining whether to grant a stay, the board shall consider the factors listed in Iowa Code section 17A.19(5)(c).

7.28(3) A stay may be vacated by the board upon application of any party.

199—7.29(17A,476) Emergency adjudicative proceedings.

7.29(1) *Necessary emergency action.* To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, and consistent with the Constitution and other provisions of law, the board may issue an emergency adjudicative order in compliance with Iowa Code section 17A.18A to order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the agency. Before issuing an emergency adjudicative order, the board may consider factors including, but not limited to, the following:

a. Whether there has been a sufficient factual investigation to provide reasonably reliable information under the circumstances;

b. Whether the specific circumstances that pose immediate danger to the public health, safety, or welfare are likely to be continuing;

c. Whether the person required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety, or welfare;

d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety, or welfare; and

e. Whether the specific action contemplated by the board is necessary to avoid the immediate danger.

7.29(2) *Issuance of order.*

a. An emergency adjudicative order shall contain findings of fact, conclusions of law, and policy reasons for the decision if it is an exercise of the board's discretion, to justify the determination of an immediate danger and the board's decision to take immediate action.

b. The written emergency adjudicative order shall be immediately delivered to persons who are required to comply with the order by the most reasonably available method, which may include one or more of the following methods: notice through the electronic filing system; personal delivery; certified mail; first-class mail; fax; or E-mail. To the degree practical, the board shall select the method or methods most likely to result in prompt, reliable delivery.

c. Unless the written emergency adjudicative order is delivered by personal service on the day issued, the board shall make reasonable efforts to contact the persons who are required to comply with the order by telephone, in person, or otherwise.

7.29(3) *Completion of proceedings.* Issuance and delivery of a written emergency adjudicative order will normally include notification of a procedural schedule for completion of the proceedings.

These rules are intended to implement Iowa Code chapter 17A and sections 474.5 and 476.2.

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1 Objection to emergency filing—filed 9/15/81

2 Effective date of 7.4(1)*"f"*(2) delayed 70 days by Administrative Rules Review Committee.

3 See Utilities Division, IAB 7/30/86

4 Effective date of subrule 7.1(8) delayed 70 days by the Administrative Rules Review Committee at its meeting held October 10, 2006.

CHAPTER 8
CIVIL PENALTIES
[Prior to 10/8/86, Commerce Commission[250]]

199—8.1(476) Civil penalty for willful violation. The board may assess a penalty against a public utility upon finding that the utility willfully violated a provision of Iowa Code chapter 476, a board rule, or a provision of an order lawfully issued by the board.

A willful violation exists where the evidence shows that the utility intentionally or knowingly violated a board rule, a provision of an order lawfully issued by the board in a proceeding involving the same utility, or a provision of Iowa Code chapter 476.

This rule is intended to implement Iowa Code sections 476.20 and 476.51.

199—8.2(476) Procedure. A request for imposition of civil penalties must be made within 180 days of the date the party filing the request knew or should have known of the alleged violation. The request shall be considered as filed on the date of the United States Postal Service postmark or the date personal service is made. The request shall be in writing and must be delivered by United States Postal Service or personal service. The 180-day limit is tolled by commencing an informal complaint proceeding in accordance with Iowa Administrative Code 199—Chapter 6.

8.2(1) *Request by nonboard party.* As a part of a request for a formal proceeding in accordance with Iowa Administrative Code 199—6.5(476) or as part of any other contested case proceeding, the consumer advocate or any other person may request the board to impose civil penalties against a utility for a willful violation of a provision of Iowa Code chapter 476, a board rule, or an order lawfully issued by the board in a proceeding involving the same utility.

In a complaint proceeding, the request for imposition of civil penalties must appear on the face of a request for formal proceeding filed in accordance with the provisions of Iowa Administrative Code 199—Chapter 6. Upon receiving approval from the board, a party may amend its request for a formal proceeding to request the board to impose civil penalties at any time prior to the close of the submission of evidence. In any other contested case proceeding, the request must be made by written motion prior to the close of the submission of evidence.

8.2(2) *Board request.* On its own motion, the board may raise the issue of imposing civil penalties against a utility for a willful violation of Iowa Code chapter 476, a board rule, or a provision of an order lawfully issued by the board in a proceeding involving the same utility, as part of a contested case proceeding with adequate notice or by commencing a formal complaint proceeding in accordance with the provisions of Iowa Administrative Code 199—Chapter 6.

8.2(3) *Hearing.* If necessary, a hearing shall be held in accordance with the provisions of Iowa Administrative Code 199—Chapter 6 where there is an issue of adjudicative fact. The utility may waive its right to a hearing. A separate hearing on an adjudicative fact is not required if the same issue of adjudicative fact has been fully litigated by the identical parties with adequate notice as part of a contested case proceeding.

This rule is intended to implement Iowa Code sections 476.20 and 476.51.

199—8.3(476) Penalties assessed. The board, in its discretion, may levy penalties of not more than $100 per violation or $1000 per day of a continuing violation, whichever is greater.

In determining the amount of penalty to be imposed for a willful violation, the board may consider the following factors in exercising its statutory discretion to impose civil penalties up to the maximum amount:

1. Gravity of the offense;
2. The utility's prior record of Code, rule, and order violations;
3. The actual or potential harm or injury to an individual or the public resulting from the violation.

This rule is intended to implement Iowa Code sections 476.20 and 476.51.

199—8.4(476) Payment of penalty. The remittance shall be made payable to the Iowa Utilities Board and forwarded to the Executive Secretary, Iowa Utilities Board, 1375 E. Court Avenue, Room 69, Des Moines, Iowa 50319-0069. Remittance must be made within 35 days after final agency action.

This rule is intended to implement Iowa Code sections 476.20 and 476.51.

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199—8.5(476) Rate-regulated utilities. A penalty assessed by the board pursuant to this rule against a utility must be recorded by the utility as a below-the-line, miscellaneous deduction from the income account and shall not be included directly or indirectly in the utility's rates or charges to customers.

This rule is intended to implement Iowa Code sections 476.20 and 476.51.

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CHAPTER 10
INTRASTATE GAS AND UNDERGROUND GAS STORAGE
[Prior to 10/8/86, Commerce Commission[250]]

199—10.1(479) General information.

10.1(1) *Authority.* The standards relating to intrastate gas and underground gas storage in this chapter are prescribed by the Iowa utilities board (board) pursuant to Iowa Code section 479.17.

10.1(2) *Purpose.* The purpose of this chapter is to establish standards for a petition for a permit to construct, maintain, and operate an intrastate gas pipeline and for the underground storage of gas. In addition, the rules in this chapter set forth safety standards for the construction, maintenance, and condition of pipelines, underground storage facilities, and equipment used in connection with pipelines and facilities.

10.1(3) *Definitions.* Technical terms not defined in this chapter shall be as defined in the appropriate standard adopted in rule 199—10.12(479). For the administration and interpretation of this chapter, the following words and terms, when used in these rules, shall have the meanings indicated below:

"Approximate right angle" means within 5 degrees of a 90 degree angle.

"Board" means the utilities board within the utilities division of the department of commerce.

"Multiple line crossing" means a point at which a proposed pipeline will either overcross or undercross an existing pipeline.

"Permit" means a new, amended, or renewal permit issued after appropriate application to and determination by the board.

"Pipeline" means any pipe, pipes, or pipelines used for the intrastate transportation or transmission of any solid, liquid, or gaseous substance, except water.

"Pipeline company" means any person, firm, copartnership, association, corporation, or syndicate engaged in or organized for the purpose of owning, operating, or controlling pipelines for the intrastate transportation or transmission of any solid, liquid, or gaseous substance, except water.

"Renewal permit" means the extension and reissuance of a permit after appropriate application to and determination by the board.

"Underground storage" means storage of gas in a subsurface stratum or formation of the earth.

10.1(4) *Railroad crossings.* Where these rules call for the consent or other showing of right from a railroad for a railroad crossing, an affidavit filed by a petitioner which states that proper application for approval of railroad crossing has been made, that a one-time crossing fee has been paid as provided for in rule 199—42.3(476), and that 35 days have passed since mailing of the application and payment with no claim of special circumstance or objection from the railroad will be accepted as a showing of consent for the crossing.

199—10.2(479) Petition for permit.

10.2(1) A petition for a permit shall be made to the board upon the form prescribed and shall include all required exhibits. The petition shall be considered as filed upon receipt at the office of the board. An original and two copies of the petition and exhibits shall be filed, unless the petition and exhibits are filed electronically pursuant to the board's electronic filing rules at 199—Chapter 14. Required exhibits shall be in the following form:

a. Exhibit A. A legal description showing, at minimum, the general direction of the proposed route through each quarter section of land to be crossed, including township and range and whether on private or public property, public highway or railroad right-of-way, together with such other information as may be deemed pertinent. Construction deviation of 660 feet (one-eighth mile) from proposed routing will be permitted.

If it becomes apparent that there will be deviation of greater than 660 feet (one-eighth mile) in some area from the proposed route as filed with the board, construction of the line in that area shall be suspended. Exhibits A, B, E, and F reflecting the deviation shall be filed, and the procedures hereinafter set forth to be followed upon the filing of a petition for permit shall be followed.

b. Exhibit B. Maps showing the proposed routing of the pipeline. Strip maps will be acceptable. Two copies of such maps shall be filed. The maps may be to any scale appropriate for the level of detail to be shown, but not smaller than one inch to the mile. The following minimum information shall be provided:

(1) The route of the pipeline which is the subject of the petition, including the starting and ending points, and when paralleling a road or railroad, which side it is on. Multiple pipelines on the same right-of-way shall be indicated.

(2) The name of the county, county and section lines, and section, township and range numbers.

(3) The location and identity of public roads, railroads, major streams or bodies of water, and other pertinent natural or man-made features influencing the route.

(4) The name and corporate limits of cities, and the name and boundaries of any public lands or parks.

(5) Other pipelines and the identity of the owner.

c. Exhibit C. A showing on forms prescribed by this board of engineering specifications covering the engineering features, materials and manner of construction of the proposed pipeline, its approximate length, diameter and the name and location of each railroad and primary highway and the number of secondary highways to be crossed, if any, and such other information as may be deemed pertinent.

d. Exhibit D. Satisfactory attested proof of solvency and financial ability to pay damages in the sum of $250,000 or more; or surety bond satisfactory to this board in the penal sum of $250,000 with surety approved by this board, conditioned that the petitioner will pay any and all damages legally recovered against it growing out of the operation of its pipeline or gas storage facilities in the state of Iowa; security satisfactory to this board as a guarantee for the payment of damages in the sum of $250,000; or satisfactory proofs that the company has property subject to execution within this state, other than pipelines, of a value in excess of $250,000.

e. Exhibit E. Consent or other showing of right of appropriate public highway authorities, or railroad companies, where the pipeline will be placed longitudinally on, over or under, or at other than an approximate right angle to railroad tracks or highway, when such consent is obtained prior to filing of the petition and hearing shall be filed with the petition.

If the exact and specific route is uncertain at the time of petition, a statement shall be made by petitioner that all consents or other showing of right will be obtained prior to construction and copies filed with this board.

f. Exhibit F. This exhibit shall contain the following:

(1) A statement of the purpose of the project and a description of how the services rendered by the pipeline will promote the public convenience and necessity.

(2) A general statement covering each of the following topics: the nature of the lands, waters, and public or private facilities to be crossed; the possible use of alternative routes; the relationship of the proposed pipeline to present and future land use and zoning ordinances; and the inconvenience or undue injury which may result to property owners as a result of the proposed project.

(3) For an existing pipeline, the year of original construction and a description of any amendments or reportable changes since the permit or latest renewal permit was issued.

g. Exhibit G. If informational meetings were required, an affidavit that such meetings were held in each county affected by the proposed project and the time and place of each meeting. Copies of the mailed notice letter and the published notice(s) of the informational meeting shall be attached to the affidavit.

h. Exhibit H. This exhibit is required only if the petition requests the right of eminent domain. The extent of the eminent domain request may be uncertain at the time the petition is filed. However, this exhibit must be in final form before a hearing is scheduled. It shall consist of a map of the route showing the location of each property for which the right of eminent domain is sought and for each such property:

(1) The legal description of the property.

(2) The legal description of the desired easement.

(3) A specific description of the easement rights being sought.

(4) The names and addresses of the owners of record and parties in possession of the property.

(5) A map drawn to an appropriate scale showing the boundaries of the property, the boundaries and dimensions of the proposed easement, the location of pipelines or pipeline facilities within the proposed easement, the location of and distance to any building within 300 feet of the proposed pipeline, and any other features pertinent to the location of the line to the rights being sought.

i. Exhibit I. If pipeline construction on agricultural land as defined in 199—subrule 9.1(3) is proposed, a land restoration plan shall be prepared and filed as provided in rule 199—9.2(479,479A,479B).

j. Underground storage. If permission is sought to construct, maintain and operate facilities for underground storage of gas, the petition shall include the following information, in addition to that stated above:

(1) A description of the public or private highways, grounds and waters, streams and private lands of any kind under which the storage is proposed, together with a map.

(2) Maps showing the location of proposed machinery, appliances, fixtures, wells, and stations necessary for the construction, maintenance, and operation of the facilities.

k. Other exhibits. The board may require filing of additional exhibits if further information on a particular project is deemed necessary.

10.2(2) Petitions proposing new pipeline construction on an existing easement where the company has previously constructed a pipeline shall include a statement indicating whether any unresolved damage claims remain from the previous pipeline construction, and if so shall provide the name of each landowner or tenant, a legal description of the property involved, and the status of proceedings to settle the claim.

A petition for permit proposing a new pipeline construction on an existing easement where the company has previously constructed a pipeline will not be acted upon by the board if a damage claim from the installation of its previous pipeline has not been determined by negotiation, arbitration, or court action. This paragraph will not apply if the damage claim is under litigation or arbitration.

10.2(3) Statement of damage claims.

a. A petition for permit proposing new pipeline construction will not be acted upon by the board if the company does not have on file with the board a written statement as to how damages resulting from the construction of the pipeline shall be determined and paid.

The statement shall contain the following information: the type of damages which will be compensated for, how the amount of damages will be determined, the procedures by which disputes may be resolved, and the manner of payment.

The statement shall be amended as necessary to reflect changes in the law, company policy, or the needs of a specific project.

b. A copy of this statement shall be mailed with the notice of informational meeting as provided for in Iowa Code section 479.5. Where no informational meeting is required, a copy shall be provided to each affected party prior to entering into negotiations for payment of damages.

c. Nothing in this rule shall prevent a party from negotiating with the company for terms which are different, more specific, or in addition to the statement filed with the board.

This rule is intended to implement Iowa Code sections 479.5, 479.17, 479.26, 479.42, and 479.43.

199—10.3(479) Informational meetings. Informational meetings shall be held for any proposed pipeline project over five miles in length, including both the current project and future anticipated extensions, and which is to be operated at a pressure of over 150 pounds per square inch. A separate informational meeting shall be held in each county in which real property or rights therein would be affected. Informational meetings shall be held not less than 30 days nor more than two years prior to the filing of the petition for pipeline permit and shall comply with the following:

10.3(1) *Facilities.* Prospective petitioners for a permit shall be responsible for all negotiations and compensation for a suitable facility to be used for each informational meeting, including but not limited to a building or facility which is in substantial compliance with the requirements of the Americans with Disabilities Act Accessibility Guidelines, Chapter 4, where such a building or facility is reasonably available.

10.3(2) *Location.* The informational meeting location shall be reasonably accessible to all persons, companies or corporations which may be affected by the granting of a permit.

10.3(3) *Route deviation.* Prospective petitioners desiring a route corridor to permit minor route deviations beyond the proposed permanent right of way width shall include as affected all parties within the desired corridor. Prospective petitioners may also provide notice to affected parties on alternative route corridors.

10.3(4) *Notices.* Announcement by mailed and published notice of the meeting shall be given to affected parties of interest in real estate. Affected parties of interest in real estate are those persons, companies or corporations listed on the tax assessment roles as responsible for payment of real estate taxes and parties in possession of or residing on the property over which the prospective petitioner will seek easements.

a. The notice shall set forth the name of the applicant; the applicant's principal place of business; the general description and purpose of the proposed project; the general nature of the right-of-way desired; the possibility that the right-of-way may be acquired by condemnation if approved by the board; a map showing the route of the proposed project; a description of the process used by the board in making a decision on whether to approve a permit including the right to take property by eminent domain; that the landowner has a right to be present at such meeting and to file objections with the board; and designation of the time and place of the meeting; and contain the following statement: Persons with disabilities requiring assistive services or devices to observe or participate should contact the Utilities Board at (515)725-7300 in advance of the scheduled date to request that appropriate arrangements be made. Mailed notices shall also include a copy of the statement of damage claims as required by 10.2(3)*"b."*

b. The prospective petitioner shall cause a written copy of the meeting notice to be served, by certified United States mail with return receipt requested, on all affected parties whose address is known. The certified meeting notice shall be deposited in the U.S. mails not less than 30 days prior to the date of the meeting.

c. The prospective petitioner shall cause the meeting notice, including the map, to be published once in a newspaper of general circulation in the county at least one week and not more than three weeks prior to the date of the meeting. Publication shall be considered as notice to affected parties whose residence is not known provided a good-faith effort to notify can be demonstrated by the pipeline company.

10.3(5) *Personnel.* The prospective petitioner shall provide qualified personnel to speak for it in matters relating to the following:

a. Service requirements and planning which have resulted in the proposed project.

b. When the pipeline will be constructed.

c. In general terms, the elements involved in pipeline construction.

d. In general terms, the rights which the prospective petitioner will seek to acquire through easements.

e. Procedures to be followed in contacting affected parties for specific negotiations in acquiring voluntary easements.

f. Methods and factors used in arriving at an offered price for voluntary easements including the range of cash amount for each component.

g. Manner in which voluntary easement payments are made, including discussion of conditional easements, signing fees and time of payment.

h. Other factors or damages not included in the easement for which compensation is made, including features of interest to affected parties but not limited to computation of amounts and manner of payment.

10.3(6) *Coordinating with board.* The date, time, and location of the informational meeting shall be selected after consultation with the board to allow for scheduling of presiding officers.

This rule is intended to implement Iowa Code section 479.5.

[Editorial change: IAC Supplement 12/29/10]

199—10.4(479) Notice of hearing.

10.4(1) When a proper petition for permit is received by the board, it shall be docketed for hearing and the petitioner shall be advised of the time and place of hearing, except as provided for in rule 199—10.8(479). Petitioner shall also be furnished copies of the official notice of hearing which petitioner shall cause to be published once each week for two consecutive weeks in a newspaper of general circulation in each county in or through which construction is proposed. The second publication shall be not less than 10 nor more than 30 days prior to the date of the hearing. Proof of such publication shall be filed prior to or at the hearing.

The published notice shall include a map showing either the pipeline route or the area affected by underground gas storage, or a telephone number and an address through which interested persons can obtain a copy of a map from petitioner at no charge. If a map other than that filed as Exhibit B will be published or provided, a copy shall be filed with the petition.

10.4(2) If a petition for permit seeks the right of eminent domain, petitioner shall, in addition to the published notice of hearing, serve a copy of the notice of hearing to the owners and parties in possession of lands over which eminent domain is sought. A copy of the Exhibit H filed with the board for the affected property shall accompany the notice. Service shall be by certified United States mail, return receipt requested, addressed to their last known address, and this notice shall be mailed not later than the first day of publication of the official notice of hearing on the petition. Not less than five days prior to the date of the hearing, the petitioner shall file with the board a certificate of service showing all addresses to which notice was sent by certified mail and the date of the mailing.

10.4(3) If a petition does not seek the right of eminent domain, but all required interests in private property have not yet been obtained, a copy of the notice of hearing shall be served upon the owners and parties in possession of those lands. Service shall be by ordinary mail, addressed to the last known address, mailed not later than the first day of publication of the official notice. A copy of each letter of notification, or one copy of the letter accompanied by a written statement listing all parties to which it was mailed and the date of mailing, shall be filed with the board not less than five days prior to the hearing.

199—10.5(479) Objections. All whose rights or interests may be affected by the object of a petition may file written objection thereto. Such written objection shall be filed with the secretary of this board not less than five days prior to date of hearing. This board may, for good cause shown, permit filing of objections less than five days prior to hearing, but in such event petitioner shall be granted a reasonable time to meet such objections.

199—10.6(479) Hearing. Hearing shall be not less than 10 or more than 30 days from the date of last publication of notice of hearing.

Petitioner shall be represented by one or more duly authorized representatives or counsel or both. This board may examine the proposed route of the pipeline or location of the underground storage facilities which are the object of the petition or may cause examination to be made on its behalf by an engineer of its selection. One or more members of this board or a duly appointed administrative law judge shall consider the petition and any objections filed thereto and may hear testimony deemed appropriate. One or more petitions may be considered at the same hearing. Petitions may be consolidated. Hearing shall be held in the office of this board or at any other place within the state of Iowa as this board may designate. Any hearing permitted by these rules in which there are no objections, interventions or material issues in dispute may be conducted by telephonic means. Notice of the telephonic hearings shall be given to parties within a reasonable time prior to the date of hearing.

199—10.7(479) Pipeline permit. If after hearing and appropriate findings of fact it is determined a permit should be granted, a pipeline permit shall be issued. Otherwise the petition shall be dismissed with or without prejudice. Where proposed construction has not been established definitely, the permit will be issued on the route or location as set forth in the petition, subject to deviation of up to 660 feet (one-eighth mile) on either side of the proposed route. If the proposed construction is not completed

within two years from the date of issue, subject to extension at the discretion of the board, the permit shall be void and of no further force or effect. Upon completion of the proposed construction, maps accurately showing the final routing of the pipeline shall be filed with the board.

A pipeline permit shall normally expire 25 years from date of issue. No permit shall ever be granted for a longer period than 25 years.

199—10.8(479) Renewal permits. A petition for renewal of an original or previously renewed pipeline permit may be filed at any time subsequent to issuance of the permit and prior to expiration of the permit. The petition shall be made on the form prescribed by the board. Instructions for the petition are included as a part of the form. The procedure for petition for permit shall be followed with respect to publication of notice, objections, and assessment of costs. If review of the petition finds unresolved issues of fact or law, or if an objection is filed within 20 days of the second publication of the published notice, the matter will be set for hearing. If a hearing is not required, a renewal permit will be issued upon the filing of the proof of publication required by 199—10.4(479). Renewal permits shall normally expire 25 years from date of issue. No permit shall be granted for a period longer than 25 years. The same procedure shall be followed for subsequent renewals.

This rule is intended to implement Iowa Code sections 476.2 and 479.23.

199—10.9(479) Amendment of permits.

10.9(1) An amendment of pipeline permit by the board is required in any of the following circumstances:

a. Construction of a pipeline paralleling an existing line of petitioner;

b. Extension of an existing pipeline of petitioner by more than 660 feet (one-eighth mile);

c. Relocation of an existing pipeline of petitioner which:

(1) Relocates the pipeline more than 660 feet (one-eighth mile) from the route approved by the board; or

(2) Involves relocation requiring new or additional interests in property for five miles or more of pipe to be operated at over 150 psig. Informational meetings as provided for by rule 199—10.3(479) shall be held for these relocations.

d. Contiguous extension of an underground storage area of petitioner; or

e. Modification of any condition or limitation placed on the construction or operation of the pipeline in the final order granting the pipeline permit.

10.9(2) Petition for amendment. The petition for amendment of an original or renewed pipeline permit shall include the docket number and issue date of the permit for which amendment is sought and shall clearly state the purpose of the petition. If the petition is for construction of additional pipeline facilities or expansion of an underground storage area, the same exhibits as required for a petition for permit shall be attached.

The applicable procedures for petition for permit, including hearing, shall be followed. Upon appropriate determination by this board, an amendment to the permit will be issued. Such amendment shall be subject to the same conditions with respect to completion of construction within two years and the filing of final routing maps as attached to pipeline permits.

This rule is intended to implement Iowa Code sections 476.2 and 479.23.

199—10.10(479) Fees and expenses.

10.10(1) *Permit expenses.* The petitioner shall pay the actual unrecovered cost incurred by the board attributable to the processing, investigation, and inspection related to a petition requesting a pipeline permit action.

Any moneys collected by the board from other sources for chargeable activities will be deducted from billings for actual expenses submitted to the petitioner.

10.10(2) *Construction inspection.* The petitioner shall reimburse the board for the actual unrecovered expenses incurred due to inspection of pipeline construction or testing activities following from a permit action.

Any moneys collected by the board from other sources for chargeable activities will be deducted from billings for actual expenses submitted to the petitioner.

10.10(3) *Annual inspection fee.* A pipeline company shall pay an annual inspection fee on all pipelines under permit of 50 cents per mile of pipeline or fraction thereof for each inch of diameter of the pipeline located in the state of Iowa. The fee shall be paid for the calendar year in advance between January 1 and February 1 of each year. When new pipeline subject to the fee is installed, the fee shall be paid beginning the following calendar year. Pipelines removed from service shall remain subject to the fee until the calendar year following the year the board is notified of the removal from service in accordance with rule 199—10.18(479).

199—10.11(479) Inspections. This board shall from time to time examine the construction, maintenance and condition of pipelines, underground storage facilities and equipment used in connection with pipelines or facilities in the state of Iowa to determine if the same are unsafe or dangerous and whether they comply with the appropriate standards of pipeline safety. One or more members of this board, or one or more duly appointed representatives of the board may enter upon the premises of any pipeline company within the state of Iowa for the purpose of making the inspections.

199—10.12(479) Standards for construction, operation and maintenance.

10.12(1) All pipelines, underground storage facilities, and equipment used in connection therewith shall be designed, constructed, operated, and maintained in accordance with the following standards:

a. 49 CFR Part 191, "Transportation of Natural and Other Gas by Pipeline; Annual Reports, Incident Reports, and Safety-Related Condition Reports," as amended through August 19, 2009.

b. 49 CFR Part 192, "Transportation of Natural and Other Gas by Pipeline: Minimum Federal Safety Standards," as amended through August 19, 2009.

c. 49 CFR Part 199, "Drug and Alcohol Testing," as amended through August 19, 2009.

d. ASME B31.8 - 2007, "Gas Transmission and Distribution Piping Systems."

e. 199 IAC 9, "Restoration of Agricultural Lands During and After Pipeline Construction."

f. At railroad crossings, 199 IAC 42.7(476), "Engineering standards for pipelines."

Conflicts between the standards established in paragraphs 10.12(1)*"a"* through *"f"* or between the requirements of rule 199—10.12(479) and other requirements which are shown to exist by appropriate written documentation filed with the board shall be resolved by the board.

10.12(2) If review of Exhibit C, or inspection of facilities which are the subject of a permit petition, finds noncompliance with the standards adopted in this rule, no final action will be taken by the board on the petition without a satisfactory showing by the petitioner that the noncompliance has been or will be corrected.

10.12(3) Pipelines in tilled agricultural land shall be installed with a minimum cover of 48 inches.

[**ARC 7962B**, IAB 7/15/09, effective 8/19/09]

199—10.13(479) Minimum safety standards. Rescinded IAB 2/21/90, effective 3/28/90.

199—10.14(479) Crossings of highways, railroads, and rivers.

10.14(1) Iowa Code chapter 479 gives the Iowa utilities board primary authority over the routing of pipelines. However, highway and railroad authorities and environmental agencies may have a jurisdictional interest in the routing of the pipeline, including requirements that permits or other authorizations be obtained prior to construction for crossings of highway or railroad right-of-way, or rivers or other bodies of water.

Except for other than approximate right angle crossings of highway or railroad right-of-way, the approval of other authorities need not be obtained prior to petitioning the board for a pipeline permit. It is recommended the appropriate other authorities be contacted well in advance of construction to determine what restrictions or conditions may be placed on the crossing, and to obtain information on any proposed reconstruction or relocation of existing facilities which may impact the routing of the pipeline.

10.14(2) Pipeline routes which include crossings of highway or railroad right-of-way at other than an approximate right angle, or longitudinally on such right-of-way, shall not be constructed unless a showing

of consent by the appropriate authority has been provided by the petitioner as required in paragraph 10.2(1)*"e."*

199—10.15(479) River crossings. Rescinded IAB 3/6/91, effective 4/10/91.

199—10.16(479) When a permit is required. A pipeline permit shall be required for any pipeline which will be operated at a pressure of over 150 pounds per square inch gage or which, regardless of operating pressure, is a transmission line as defined in ASME B31.8 or 49 CFR Part 192. Questions on whether a pipeline requires a permit are to be resolved by the board.

199—10.17(479) Accidents and incidents. Any pipeline incident or accident which is reportable to the U.S. Department of Transportation under 49 CFR Part 191 as amended through August 19, 2009, shall also be reported to the board, except that the minimum economic threshold of damage required for reporting to the board is $15,000. Duplicate copies of any written accident reports and safety-related condition reports submitted to the U.S. Department of Transportation shall be provided to the board.
[**ARC 7962B**, IAB 7/15/09, effective 8/19/09]

199—10.18(479) Reportable changes to pipelines under permit.

10.18(1) The board shall receive prior notice of any of the following actions affecting a pipeline under permit:

a. Abandonment or removal from service.

b. Relocation of more than 300 feet from the original alignment, or any relocation that would bring the pipeline within 300 feet of an occupied residence. Relocations of 660 feet (one-eighth mile) or more shall require the filing of a petition for permit.

c. Pressure test, uprating, or increase in operating pressure.

d. Change in product being transported.

e. Replacement of a pipeline or significant portion thereof, not including short repair sections of pipe at least as strong as the original pipe.

f. Extensions of existing pipelines by 660 feet (one-eighth mile) or less.

10.18(2) The notice shall include the docket and permit numbers of the pipeline, the location involved, a description of the proposed activity, anticipated dates of commencement and completion, revised maps and technical specifications, where appropriate, and the name and telephone number of a person to contact for additional information.

199—10.19(479) Sale or transfer of permit.

10.19(1) No permit shall be sold without prior written approval of the board. A petition for approval shall be jointly filed by the buyer and seller, shall include assurances that the buyer is authorized to transact business in the state of Iowa; is willing and able to construct, operate, and maintain the pipeline in accordance with these rules; and if the sale is prior to completion of construction of the pipeline shall show that the buyer has the financial ability to pay up to $250,000 in damages.

10.19(2) No transfer of pipeline permit prior to completion of pipeline construction shall be effective until the person to whom the permit was issued files notice with the board of the transfer. The notice shall include the date of the transfer and the name and address of the transferee.

10.19(3) The board shall receive notice from the transferor of any other transfer of a pipeline permit after completion of construction.

For the purposes of this rule, reassignment of a pipeline permit as part of a corporate restructuring, with no change in pipeline operating personnel or procedures, is considered a transfer.

199—10.20(479) Amendments to rules. Rescinded IAB 6/25/03, effective 7/30/03.

These rules are intended to implement Iowa Code sections 476.2, 479.5, 479.17, 479.23, 479.26, 479.42, 479.43 and 546.7.

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[Editorial change: IAC Supplement 12/29/10]

CHAPTER 11
ELECTRIC LINES

[Previously Ch 2, renumbered 10/20/75 Supp.]
[Prior to 10/8/86, Commerce Commission[250]]

199—11.1(478) General information.

11.1(1) *Authority.* The standards pertaining to electric transmission lines in this chapter are prescribed by the Iowa utilities board pursuant to Iowa Code sections 478.18(1), 478.19 and 478.20. This chapter shall apply to any individual, company, corporation, or city engaged in the construction, operation, and maintenance of electric transmission lines to the extent provided in Iowa Code chapter 478.

11.1(2) *Purpose.* The purpose of this chapter is to establish standards for electric franchise proceedings before the Iowa utilities board.

11.1(3) *Iowa electrical safety code.* Overhead and underground electric supply line minimum requirements to be applied in installation, operation, and maintenance are found in 199—Chapter 25, Iowa electrical safety code.

11.1(4) *Date of filing.* A petition for franchise shall be considered filed with the board on the date of the United States Postal Service postmark if the filing is made by mail, or on the date received at the board's records center if the filing is made in person or sent other than by United States mail.

11.1(5) *Franchise—when required.* An electric franchise shall be required for the construction, operation, and maintenance of any electric line which is capable of operating at 69,000 volts or more outside of cities, except that a franchise is not required for electric lines located entirely within the boundaries of property owned by an electric company or an end user.

11.1(6) *Definitions.* For the administration and interpretation of this chapter, the following words and terms, when used in these rules, shall have the meanings indicated below:

"Board" means the utilities board within the utilities division of the department of commerce.

"Capable of operating" shall mean the standard voltage rating at which the line, wire or cable can be operated consistent with the level of the insulators and the conductors used in construction of the line, wire, or cable based on manufacturer's specifications, industry practice, and applicable industry standards.

11.1(7) *Route selection.* The planning for a route that is the subject of a petition for franchise must begin with routes that are near and parallel to roads, railroad rights-of-way, or division lines of land, according to the government survey, consistent with the provisions of Iowa Code section 478.18(2). When a route near and parallel to these features has points where electric line construction is not practicable and reasonable, deviations may be proposed at those points, when accompanied by a proper evidentiary showing, generally of engineering reasons, that the initial route or routes examined did not meet the practicable and reasonable standard. Although deviations based on landowner preference or minimizing interference with land use may be permissible, the petitioner must be able to demonstrate that route planning began with a route or routes near and parallel to roads, railroad rights-of-way, or division lines of land.

Further, no transmission line shall be constructed outside of cities, except by agreement, within 100 feet of any dwelling house or other building, except where such line crosses or passes along a public highway or is located alongside or parallel with the right-of-way of any railroad company, consistent with the provisions of Iowa Code section 478.20.

11.1(8) *Railroad crossings.* Where a petition for temporary construction permit is made as provided for in Iowa Code section 478.31, an affidavit filed by the petitioner which states that proper application for approval of railroad crossing has been made, that a one-time crossing fee has been paid as provided for in rule 199—42.3(476) and that 35 days have passed since mailing of the application and payment with no claim of special circumstance or objection from the railroad will be accepted as a showing of railroad approval for the crossing.

11.1(9) *Eligibility for abbreviated franchise process.* Petitions for an electric franchise or an amendment to a franchise may be filed pursuant to the abbreviated franchise process set forth in 2009

Iowa Acts, Senate File 279 [Iowa Code Supplement section 478.1(5)], if the following requirements are met:

a. The project consists of the conversion, upgrading, or reconstruction of an existing electric line operating at 34.5 kV to a line capable of operating at 69 kV.

b. The project will be on substantially the same right-of-way as an existing 34.5 kV line. For purposes of this subrule, "substantially the same right-of-way" means that the new or additional interests in private property right-of-way will be required for less than one mile of the proposed project length. Easements required for conductor and crossarm overhang of private property or for anchor easements shall not be considered when determining the length of additional interests in private property right-of-way.

c. The project will have substantially the same effect on the underlying properties as the existing 34.5 kV line.

d. The completed line will comply with the Iowa electrical safety code found in 199—Chapter 25.

e. Notice will be provided as required in subrule 11.5(11).

f. The petitioner does not request the power of eminent domain.

g. The petitioner agrees to pay all costs and expenses of the franchise proceeding.

Petitions that do not comply with the eligibility requirements in paragraphs 11.1(9)*"a"* through *"g"* shall be rejected.

[**ARC 8435B**, IAB 12/30/09, effective 2/3/10]

199—11.2(478) Forms of petition for franchise, extension, or amendment of franchise.

11.2(1) *Forms of petition for a new or amended franchise.* A petition for a new or amended franchise filed with the board shall be made in the following manner. A petition shall be made on forms prescribed by the board, shall be notarized, and shall have all required exhibits attached. Exhibits in addition to those required by this rule may be attached when appropriate.

a. Exhibit A. A legal description of the route. The description shall include the name of the county, the maximum and nominal voltages, the beginning and ending points of the line, and whether the route is on public, private, or railroad right-of-way. In the case of the multicounty projects, the description shall identify all counties involved in the total project and any termini located in other counties.

b. Exhibit B. A map showing the route of the line drawn with reasonable accuracy considering the scale. Two copies shall be submitted. The map may be to any scale appropriate for the level of detail to be shown, but not smaller than one inch to the mile. The following minimum information shall be provided:

(1) The route of the electric line which is the subject of the petition, including starting and end points and, when paralleling a road or railroad, which side it is on. Line sections with double circuit construction or underbuild shall be designated.

(2) The name of the county, county and section lines, section numbers, and the township and range numbers.

(3) The location and identity of roads, major streams and bodies of water, and any other pertinent natural or man-made features influencing the route.

(4) The name and corporate limits of cities.

(5) The name and boundaries of any public lands or parks, recreational areas, preserves or wildlife refuges.

(6) All electric supply lines, including petitioner's within six-tenths of a mile of the route, including the nominal voltage and whether overhead or buried, and the name and address of the owners. Any lines to be removed or relocated shall be designated.

(7) The location of railroad rights-of-way, including the name and address of the owners.

(8) The location of airports or landing strips within one mile of the route, along with the name and address of the owners.

(9) The location of pipelines used for the transportation of any solid, liquid, or gaseous substance, except water, within six-tenths of a mile of the route, along with the name and address of the owners.

(10) The name and address of the owners of telephone, communication, or cable television lines within six-tenths of a mile of the route. The location of these lines need not be shown.

(11) The name and address of the owners of rural water districts organized pursuant to Iowa Code chapter 357A with facilities within six-tenths of a mile of the route. The location of these facilities need not be shown.

c. *Exhibit C.* Technical information and engineering specifications describing typical materials, equipment and assembly methods as specified on forms provided by the board.

d. *Exhibit D.* The exhibit shall consist of a written text containing the following:

(1) An allegation, with supporting testimony, that the line is necessary to serve a public use, plus such additional substantiated allegations as may be required by Iowa Code section 478.3(2).

(2) If the route or any portion thereof is not near and parallel to roads, railroad right-of-way, or along division lines of the lands, according to government surveys, a showing of why such parallel routing is not practicable or reasonable.

(3) If the route and manner of construction would result in separate pole lines for two or more electric supply lines occupying the same road right-of-way in a manner not in compliance with 199 IAC 11.6(1), a request that the board authorize separate pole lines and justification for the authorization.

(4) Any other information or explanations in support of the petition.

(5) If a new franchise must be sought for an existing electric line, historical information as specified in 199 IAC 11.2(2)*"d"*(1) to (4).

e. *Exhibit E.* This exhibit is required only if the petition requests the right of eminent domain. This exhibit shall be in its final form prior to issuance of the form of notice by the board pursuant to 199 IAC 11.5(2)*"a."* It shall consist of a map of the route showing the location of each property for which the right of eminent domain is sought, and for each property:

(1) The legal description of the property.

(2) The legal description of the desired easement.

(3) A specific description of the easement rights being sought.

(4) The names and addresses of all persons with an ownership interest in the property and of all tenants.

(5) A map drawn to an appropriate scale showing the boundaries of the property, the boundaries and dimensions of the proposed easement, the location of all electric lines and supports within the proposed easement, the location of and distance to any building within 100 feet of the proposed electric line, and any other features pertinent to the location of the line and its supports or to the rights being sought.

f. *Exhibit F.* The showing of notice to potentially affected parties as required by 199 IAC 11.5(4).

g. *Exhibit G.* The affidavit required by Iowa Code section 478.3 on the holding of an informational meeting. Copies of the mailed notice letter and the published notice(s) of the informational meeting shall be attached to the affidavit. This exhibit is required only if an informational meeting was conducted.

11.2(2) *Form of petition for extension of franchise.* A petition for an extension of franchise filed with the board shall be made in the following manner. A petition shall be made on forms prescribed by the board, shall be notarized, and shall have all required exhibits attached. Exhibits in addition to those required by this rule may be attached when appropriate.

a. *Exhibit A.* A legal description of the route. The description shall include the name of the county, the maximum and nominal voltages, the beginning and ending points of the line, and whether the route is on public, private, or railroad right-of-way. The description shall identify any termini located in other counties.

b. *Exhibit B.* A map showing the route of the line drawn with reasonable accuracy considering the scale. Two copies shall be submitted. The map may be to any scale appropriate for the level of detail to be shown, but not smaller than one inch to the mile. The following minimum information shall be provided:

(1) The route of the electric line which is the subject of the petition, including starting and end points and, when paralleling a road or railroad, which side it is on. Line sections with double circuit construction or underbuild shall be designated. The nominal voltage and ownership of other circuits or underbuild shall be indicated.

(2) The name of the county, county and section lines, section numbers, and the township and range numbers.

(3) The location and identity of roads, railroads, major streams and bodies of water, and any other significant natural or man-made features or landmarks.

(4) The name and corporate limits of cities.

c. *Exhibit C.* Technical information and engineering specifications describing typical materials, equipment and assembly methods as specified on forms provided by the board.

d. *Exhibit D.* The exhibit shall consist of a written text containing the following:

(1) A listing of all existing franchises for which extension in whole or in part is sought, including the docket number, franchise number, date of issue, county of location, and to whom granted.

(2) A listing of all amendments to the franchises listed in (1), including the docket number, amendment number, date of issue, and the purpose of the amendment.

(3) A description of any substantial rebuilds, reconstructions, alterations, relocations, or changes in operation not included in a prior franchise or amendment action.

(4) A description of any changes in ownership or operating and maintenance responsibility.

(5) An allegation, with supporting testimony, that the line remains necessary to serve a public use and represents a reasonable relationship to an overall plan of transmitting electricity in the public interest.

(6) Any other information or explanations in support of the petition.

11.2(3) *Form of petition for abbreviated franchise process.* A petition for a new franchise or an amendment to a franchise filed pursuant to the abbreviated franchise process set forth in 2009 Iowa Acts, Senate File 279 [Iowa Code Supplement section 478.1(5)], shall be made on forms prescribed by the board, shall be notarized, and shall have all required exhibits attached. Exhibits in addition to those required by this subrule may be attached when appropriate. The exhibits that are required to be attached are as follows:

a. *Exhibit A.* A legal description of the route. The description shall include the name of the county, the maximum and nominal voltages, the beginning and ending points of the line, and whether the route is on public, private, or railroad right-of-way. The description shall identify any termini located in other counties.

b. *Exhibit B.* A map showing the route of the line drawn with reasonable accuracy considering the scale. The map may be to any scale appropriate for the level of detail to be shown, but not smaller than one inch to the mile. The following minimum information shall be provided:

(1) The route of the electric line which is the subject of the petition, including the starting and ending points and, when parallel to a road or railroad, the side on which the line is located. Line sections with double circuit construction or underbuild shall be designated. The nominal voltage and ownership of other circuits or underbuild shall be indicated.

(2) The name of the county, county and section lines, section numbers, and the township and range numbers.

(3) The location and identity of roads, railroads, major streams and bodies of water, and any other significant natural or man-made features or landmarks.

(4) The name and corporate limits of cities.

(5) If any deviation from the existing route is proposed, the original and proposed routes shall be shown and identified.

c. *Exhibit C.* Technical information and engineering specifications describing typical materials, equipment, and assembly methods as specified on forms provided by the board.

d. *Exhibit D.* The exhibit shall consist of written text containing the following:

(1) A listing of any existing franchises that would be terminated or amended in whole or in part by this petition, including the docket number, franchise number, date of issue, county of location, and to whom granted.

(2) An allegation, with supporting testimony, that the project is eligible for the abbreviated franchise process.

(3) An allegation, with supporting testimony, that the project is necessary to serve a public use and represents an overall plan of transmitting electricity in the public interest.

(4) An explanation for any deviations from the existing line route.

e. *Exhibit E.* A statement that the right of eminent domain is not being requested.

f. *Exhibit F.* The exhibit shall consist of a showing of notice to other electric, pipeline, telephone, communication, cable television, rural water district, and railroad companies that are crossed by or in shared right-of-way with the proposed electric line.

g. *Exhibit G.* The exhibit shall consist of the form of notice to be mailed in accordance with subrule 11.5(11) to owners of and persons residing on property where construction shall occur.

[**ARC 8435B**, IAB 12/30/09, effective 2/3/10]

199—11.3(478) Additional filing instructions.

11.3(1) *Forms.* The following forms are available from the board, and the appropriate form shall be used when filing any petition. An original and three copies of the petition and exhibits shall be filed, unless the petition and exhibits are filed electronically pursuant to the board's electronic filing rules at 199—Chapter 14.

a. Petition for Franchise. Temporary Construction Permits may also be requested on this form where the permits are allowed by Iowa Code section 478.31.

b. Petition for Extension of Franchise.

c. Petition for Amendment to Franchise.

d. Petition for Permit to Survey.

e. Exhibit C: Engineering Specifications for Overhead Transmission Line.

f. Exhibit C-UG: Engineering Specifications for Underground Transmission Line.

g. Petition for Franchise or Amendment to Franchise Under Abbreviated Franchise Process.

11.3(2) *When filing is required.*

a. A petition for franchise shall be filed with the board for the construction of any electric line outside of a city which is capable of operating at a nominal voltage of 69 kilovolts or more, except that a franchise is not required for electric lines located entirely within the boundaries of property owned by an electric company or an end user.

b. A petition for extension of franchise may be filed at any time after the issuance of the franchise, but must be filed prior to its expiration. The extension of more than one franchise may be requested in a single petition, including for all franchised lines in a county as provided for in Iowa Code section 478.13.

However, an extension of franchise is unnecessary for an electric line which is capable of operating at 69 kilovolts or more, when the line has been permanently retired from operation at 69 kilovolts or more, and the board has been notified of the retirement. The line may remain in service at a lesser voltage. The notice shall include the franchise number and issue date, the docket number, and, if the entire franchised line is not retired, a map showing the location of the portion retired.

c. A petition for amendment to franchise shall be filed with the board for approval prior to:

(1) Increasing the operating voltage of any electric line, or the level to which it is capable of operating, to a voltage greater than that specified in the existing franchise.

(2) Construction of an additional circuit which is capable of operating at a nominal voltage of 69 kilovolts or more on a previously franchised line, where an additional circuit at such voltage is not authorized by the existing franchise.

(3) Relocation of a franchised electric line to a route different from that authorized by an existing franchise. For the purpose of this subrule, relocation means changing the route of an existing electric line in a manner which requires that new or additional interests in property be obtained, or that new or additional authorization be obtained from highway or railroad authorities, for a total distance of one mile or more, except that an amendment is not required for relocations made pursuant to Iowa Code section 318.9(2). Petitions for amendment to franchise may be filed for relocations of less than one mile if the right of eminent domain is sought.

(4) An amendment to franchise shall not be required for a voltage increase, additional circuit, or electric line relocation where such activity takes place entirely within the boundaries of property owned by an electric company or an end user.

11.3(3) *Form of papers.*

a. All petition papers shall be cut or folded so as not to exceed a width of 8½ inches and a length of 11 inches.

b. All petition maps or drawings shall be cut or folded so as not to exceed a width of 8½ inches and a length of 11 inches. The unfolded sheet shall be limited to a maximum size of 24 inches by 36 inches.

c. All maps and drawings submitted to the board shall be neatly and clearly drawn, shall have an appropriate legend, and shall have a title block or heading which indicates its origin and purpose.

d. Insofar as practicable, all papers, maps or drawings to be submitted as hearing exhibits shall be cut or folded so as not to exceed a width of 8½ inches and a length of 11 inches.

11.3(4) *Multiple county.* For a proposed line to be constructed in more than one county a petition for each county shall be filed in a form which provides for a general description of the total project, including a separate legal description for the line route in each county so that an official notice may be prepared for each county separately. A franchise or certificate for construction of lines or improvements will be prepared for each county separately, although they may be consolidated and acted upon by one order.

11.3(5) *Segmental ownership.*

a. Petitions covering line routes, having segments of the total line with different owners, shall establish the need to serve the public use for the total line.

b. Petitions covering line routes, having segments of the total line with different owners, shall include affidavits furnished by the other owners certifying that said other owners will actually construct a particular segment.

11.3(6) *Termini.* This means the electrically functional end points of an electric line, without which it could not serve a public use. Examples include generating stations, substations, or other electric lines. In any franchise petition the termini must be identified in Exhibit A, B, or D.

11.3(7) *Compliance with Iowa electrical safety code.* If review of Exhibit C, or inspection of an existing electric line which is the subject of a franchise petition, finds noncompliance with 199 IAC 25, the Iowa electrical safety code, no final action will be taken by the board on the petition without a satisfactory showing by petitioner that the areas of noncompliance have been or will be corrected. Any disputed safety code compliance issues will be resolved by the board.

This rule is intended to implement Iowa Code section 474.5 and chapter 478.

[**ARC 8435B**, IAB 12/30/09, effective 2/3/10]

199—11.4(478) Informational meetings. Not less than 30 days or more than two years prior to filing a petition or related petitions requesting franchise for a new transmission line which is capable of operating at 69 kilovolts (or for which line, easement will be sought for 69 kV) or more, with one or more miles of the total proposed route across privately owned real estate, the prospective petitioner(s) shall hold informational meetings in each county in which real property or real property rights will be affected. Informational meetings shall comply with the following:

11.4(1) *Facilities.* Prospective petitioners for franchise shall be responsible for all negotiations and compensation for a suitable facility to be used for each informational meeting, including but not limited to a building or facility which is in substantial compliance with the requirements of the Americans with Disabilities Act Accessibility Guidelines, Chapter 4, where such a building or facility is reasonably available.

11.4(2) *Location.* The informational meeting location shall be reasonably accessible to all persons, companies or corporations which may be affected by the granting of a franchise in that county.

11.4(3) *Personnel.* The prospective petitioner shall provide qualified personnel to speak for the petitioner in matters relating to the following:

a. Utility service requirements and planning which have resulted in the proposed construction.

b. When the line will be constructed.

c. In general terms, the physical construction, appearance and typical location of poles and conductors with respect to property lines.

d. In general terms, the rights which petitioner shall seek to acquire by easements.

e. Procedures to be followed in contacting affected parties for specific negotiations in acquiring voluntary easements.

f. Methods and factors used in arriving at an offered price for voluntary easements including the range of cash amount of each component.

g. Manner in which voluntary easement payments are made, including discussion of conditional easements, signing fees and time of payment.

h. Other factors or damages not included in the easement for which compensation is made, including features of interest to affected parties but not limited to computation of amounts and manner of payment.

i. If the undertaking is a joint effort by more than one entity, the other participants shall also be represented at the informational meeting by qualified personnel to speak for them in the matters set forth in 11.4(3)*"a"* through 11.4(3)*"h."*

11.4(4) *Coordinating with board.* The date, time, and location of the informational meeting shall be selected after consultation with the board to allow for scheduling of presiding officers.

11.4(5) *Amendments to franchise.* Prior to filing any petition for amendment to franchise where petitioner must obtain new or additional interests in real property for a total of one route mile or more, informational meetings shall be held which meet the requirements of 199 IAC 11.4(478).

11.4(6) *Length of easements.* The length of easements required for conductor and crossarm overhang of private property, even if no supporting structures are located on that land, shall be included in determining whether an informational meeting is required pursuant to Iowa Code section 478.2.

199—11.5(478) Notices.

11.5(1) *Informational meeting notice.* Announcement by mailed and published notice of the meeting shall be given to affected parties of interest in real estate. Affected parties of interest in real estate are those persons, companies or corporations listed on the tax assessment rolls as responsible for payment of real estate taxes and parties in possession of or residing on the property over which the prospective petitioner will seek easements.

a. The notice shall set forth the name of the applicant; the applicant's principal place of business; the general description and purpose of the proposed project; the general nature of the right-of-way desired; the possibility that the right-of-way may be acquired by condemnation if approved by the utilities board; a map showing the route of the proposed project; a description of the process used by the board in making a decision on whether to approve a franchise or grant the right to take property by eminent domain; that the landowner has a right to be present at such meeting and to file objections with the board; and a designation of the time and place of the meeting; and contain the following statement: Persons with disabilities requiring assistive services or devices to observe or participate should contact the Utilities Board at (515)725-7300 in advance of the scheduled date to request that appropriate arrangements be made.

b. Prospective petitioner shall cause a written copy of the meeting notice to be served, by certified United States mail with return receipt requested, on all affected parties whose residence is known. The certified article shall be deposited in the U.S. mail not less than 30 days prior to the time set for the meeting.

c. Prospective petitioner shall cause the meeting notice including the map, to be published once in a newspaper of general circulation in the county at least one week and not more than three weeks prior to the time set for the meeting. Publication shall be considered notice to affected parties whose residence is not known.

11.5(2) *Notice of franchise petition.*

a. Whenever a petition for a franchise, extension of franchise, or amendment of franchise is filed with the board, the board shall prepare a notice addressed to the citizens of each county through which the line or lines extend. The petitioner shall cause this notice to be published in a newspaper located in each county for two consecutive weeks. Proof of publication shall be filed with the board. This published notice shall constitute sufficient notice to all parties of the proceeding, except owners of record and

parties in possession of land to be crossed for which voluntary easements have not been obtained at the time of the first publication of the notice.

b. The petitioner shall, in addition to published notice, serve notice in writing of the filing of the petition to the owners of record and the parties in possession of the lands over which easements have not been obtained. The served notices shall be by ordinary mail, addressed to the last-known address, mailed not later than the first day of publication of the official notice. One copy of each letter of notification, or one copy of the letter accompanied by a written statement listing all parties to which it was mailed and the date of mailing, shall be filed with the board not later than five days after the date of second publication of the official notice.

c. Published notices of petitions for franchise or amendment of franchise, or extensions of franchise other than countywide extensions, shall include provisions whereby interested parties can examine a map of the route. When the petition is filed, petitioner shall state whether a map is to be published with the notice, or whether the notice is to include a telephone number and an address through which parties can request a map from petitioner at no charge. The map required by this subrule need not be as detailed as the Exhibit B map, but shall include at minimum the proposed route, section lines, section and township numbers, roads and railroads, city boundaries, and rivers and major bodies of water. A copy of this map shall be filed with the petition.

d. When a petition for countywide extension of franchise is filed, the petitioner shall state whether the published notice will contain a legal description of the route or will include a telephone number and an address through which parties can request a map from the petitioner at no charge. The map content shall be as described in subparagraph 11.5(2)*"c."* A copy of this map shall be filed with the petition.

11.5(3) *Notice of eminent domain proceedings.* If a petition for a franchise or amendment of franchise seeks the right of eminent domain, petitioner shall, in addition to published notice of hearing, serve the written notice required by Iowa Code section 478.6, in the form prescribed by the board, of the time and place of hearing to owners of record and parties in possession of lands over which eminent domain is sought. Service shall be by certified United States mail, return receipt requested, addressed to their last-known address, and this notice shall be mailed no later than the first day of publication of the official notice of hearing concerning the petition. The written notice shall include a copy of the Exhibit E filed with the board for the affected property. Not less than five days prior to the date of hearing, the petitioner shall file with the board the return receipt for the certified article. The ordinary mail notice of 11.5(2) is not required to parties for which statutory written notice is served in accordance with this paragraph.

11.5(4) *Notice to other parties.* Petitioners for a franchise or amendment to franchise shall give written notice by ordinary mail, mailed at the time the petition is filed with the board, accompanied by a map showing the route of the proposed electric supply line, to the affected parties described in 11.2(1)*"b"*(6) through (11) and the Iowa department of transportation. One copy of each letter of notification or one copy of the letter accompanied by a written statement listing all parties to which it was mailed, the date of mailing, and a copy of the map sent with the letters shall accompany the petition when it is filed with the board.

11.5(5) *Notice of franchised line construction.*

a. Within 90 days after completion of an electric line construction or reconstruction project authorized by a franchise or amendment to franchise, the holder of the franchise shall notify the board in writing of the completion. The notice shall include the franchise and docket numbers and the date the franchise was issued.

b. If the project is not completed by a date two years after the date of issuance of the franchise or amendment to franchise, prior to that date the holder of the franchise shall so notify the board in writing and, if construction has been initiated, shall report its progress.

c. If the facilities authorized by a franchise are not constructed in whole or in part within two years of the date the franchise is granted, or within two years after final unappealable disposition of judicial review of a franchise order or of condemnation proceedings, the franchise shall be forfeited unless the franchise holder petitions the board for an extension of time pursuant to Iowa Code section 478.21.

11.5(6) *Notice of deferred construction.* Rescinded IAB 5/14/03, effective 6/18/03.

11.5(7) *Notice of transfer or assignment of franchise.* The holder of a franchise shall notify the board in writing, when transferring any franchise or portion of a franchise, stating the applicable franchise number and docket number which are affected and a description of the route of the transmission line when less than the total franchised line is affected, together with the name of the transferee and date of transfer, not more than 30 days after the effective date of transfer.

11.5(8) *Notice of proposed construction of electric lines capable of operating only at less than 34,500 volts.* Rescinded IAB 4/8/98, effective 5/13/98.

11.5(9) *Notice of relocations not requiring an amendment to franchise.* Whenever an electric line under franchise is relocated in a manner which does not require an amendment to franchise, the holder of the franchise shall notify the board in writing of the relocation, stating the franchise and docket numbers and date of franchise issuance for the affected line, and providing revised Exhibits A and B which reflect the changes in the route.

11.5(10) *Notice of electric line reconstruction not requiring an amendment to franchise.* Whenever an electric line is reconstructed with different materials or specifications than appear on the most recent Exhibit C and an amendment to franchise is not required, the holder of the franchise shall notify the board in writing of the reconstruction, stating the franchise and docket numbers and date of franchise issuance for the affected line, and providing a revised Exhibit C which reflects the changes in the manner of construction.

11.5(11) *Notice of franchise or amendment to franchise under abbreviated franchise process.*

a. Petitioner shall provide written notice concerning the anticipated construction to the last-known address of the owners of record of the property where construction will occur and to persons residing on such property one month prior to commencement of construction. Notices may be served by ordinary mail, addressed to the last-known address of the owners of record of the property and to persons residing on such property. Petitioner must make a good-faith effort to identify and notify all owners of record and persons residing on the property.

b. The notice shall include the following information:

(1) A description of the purpose of the project and the nature of the work to be performed.

(2) A copy of the Exhibit B map.

(3) The estimated dates the construction or reconstruction will commence and end.

(4) The name, address, telephone number, and E-mail address of a representative of the petitioner who can respond to inquiries concerning the anticipated construction.

(5) For the purposes of this subrule, "construction" means physical entry onto private property by personnel or equipment for the purpose of rebuilding or reconstructing the electric line.

[**ARC 8435B**, IAB 12/30/09, effective 2/3/10; Editorial change: IAC Supplement 12/29/10]

199—11.6(478) Common and joint use.

11.6(1) *Common use construction.* Whenever an overhead electric line capable of operating at 69 kilovolts or more is built or rebuilt on public road rights-of-way located outside of cities, all parallel overhead electric supply circuits on the same road right-of-way shall be attached to the same or common line of structures unless the board authorizes, for good cause shown, the construction of separate pole lines.

11.6(2) *Joint use construction.* Rescinded IAB 5/14/03, effective 6/18/03.

11.6(3) *Relocating of lines.* When an electric supply line is to be constructed in a location occupied by an electric supply line or a communication line, the expense of relocating the existing line shall be borne by the utility proposing the new electric supply line. The electric utility proposing the new line shall not be required to pay any part of the used life of the existing line, but shall pay only the nonbetterment expense of relocating the existing line.

199—11.7(478) Termination of franchise petition proceedings.

11.7(1) Upon notice to the board by a petitioner that a franchise petition is withdrawn, if the notification is made prior to the publication of a public notice, the proceeding may be terminated and the docket closed without formal action by the board.

11.7(2) If petitioner takes no action, for a period of 12 months after written notification by the board, to cure an incomplete or deficient franchise petition, or fails to publish notice within 90 days after the form of notice is provided by the board, the board may dismiss the petition as abandoned. If dismissal would cause an existing line to be without a franchise, the board may also pursue imposition of civil penalties.

199—11.8(478) Fees and expenses. The petitioner shall pay the actual unrecovered cost incurred by the board attributable to the processing, investigation, and inspection related to a petition requesting an electric franchise.

These rules are intended to implement Iowa Code sections 474.5 and 546.7 and chapter 478.

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CHAPTER 13
HAZARDOUS LIQUID PIPELINES AND UNDERGROUND STORAGE

199—13.1(479B) General information.

13.1(1) *Authority.* The standards in this chapter relating to hazardous liquid pipelines and underground storage of hazardous liquids are prescribed by the Iowa utilities board pursuant to Iowa Code section 479B.1.

13.1(2) *Purpose.* The purpose of this chapter is to establish standards for a petition for a permit to construct, maintain, and operate a hazardous liquid pipeline and for the underground storage of hazardous liquids.

13.1(3) *Definitions.* Words and terms not otherwise defined in this chapter shall be understood to have their usual meaning. For the administration and interpretation of this chapter, the following words and terms, when used in these rules, shall have the meanings indicated below:

"Approximate right angle" means within 5 degrees of a 90 degree angle.

"Board" means the utilities board within the utilities division of the department of commerce.

"Hazardous liquid" means crude oil, refined petroleum products, liquefied petroleum gases, anhydrous ammonia, liquid fertilizers, liquefied carbon dioxide, alcohols, and coal slurries.

"Multiple line crossing" means a point at which a proposed pipeline will either cross over or under an existing pipeline.

"Permit" means a new, amended, or extended permit issued after appropriate application to and determination by the board.

"Pipeline" means any pipe or pipeline and necessary appurtenances used for the transportation or transmission of any hazardous liquid.

"Pipeline company" means any person, firm, copartnership, association, corporation, or syndicate engaged in or organized for the purpose of owning, operating, or controlling pipelines for the transportation or transmission of any hazardous liquid or underground storage facilities for the underground storage of any hazardous liquid.

"Renewal permit" means the extension and reissuance of a permit after appropriate application to and determination by the board.

"Underground storage" means storage of hazardous liquid in a subsurface stratum or formation of the earth.

13.1(4) *Railroad crossings.* Where these rules call for the consent or other showing of right from a railroad for a railroad crossing, an affidavit filed by a petitioner which states that proper application for approval of railroad crossing has been made, that a one-time crossing fee has been paid as provided for in rule 199—42.3(476) and that 35 days have passed since mailing of the application and payment with no claim of special circumstance or objection from the railroad will be accepted as a showing of consent for the crossing.

199—13.2(479B) Petition for permit.

13.2(1) A petition for a permit shall be made to the board upon the form prescribed and shall include all required exhibits. The petition shall be considered as filed upon receipt at the office of the board. An original and two copies of the petition and exhibits shall be filed, unless the petition and exhibits are filed electronically pursuant to the board's electronic filing rules at 199—Chapter 14. Required exhibits shall be in the following form:

a. Exhibit A. A legal description showing, at minimum, the general direction of the proposed route through each quarter section of land to be crossed, including township and range and whether on private or public property, public highway or railroad right-of-way, together with other information as may be deemed pertinent. Construction deviation of 660 feet (one-eighth mile) from proposed routing will be permitted.

If it becomes apparent there will be a deviation of greater than 660 feet (one-eighth mile) in some area from the proposed route as filed with the board, construction of the line in the area shall be suspended.

Exhibits A, B, E, and F reflecting the deviation shall be filed, and the procedure set forth shall be followed upon the filing of a petition for amendment of a permit.

b. Exhibit B. Maps showing the proposed routing of the pipeline. Strip maps will be acceptable. Two copies of the maps shall be filed. The maps may be to any scale appropriate for the level of detail to be shown, but not smaller than one inch to the mile. The following minimum information shall be provided:

(1) The route of the pipeline which is the subject of the petition, including the starting and ending points, and when paralleling a road or railroad, which side it is on. Multiple pipelines on the same right-of-way shall be indicated.

(2) The name of the county, county and section lines, and section, township and range numbers.

(3) The location and identity of public roads, railroads, major streams or bodies of water, and other pertinent natural or man-made features influencing the route.

(4) The name and corporate limits of cities and the name and boundaries of any public lands or parks.

(5) Other pipelines and the identity of the owner.

c. Exhibit C. An explanation of the purpose of the proposed project and a general description of the proposed pipeline, including its approximate length, size, products carried, and other information as may be pertinent to describe the project.

d. Exhibit D. Satisfactory attested proof of solvency and financial ability to pay damages in the sum of $250,000 or more; or surety bond satisfactory to the board in the penal sum of $250,000 with surety approved by the board, conditioned that the petitioner will pay any and all damages legally recovered against it growing out of the operation of its pipeline or gas storage facilities in the state of Iowa; security satisfactory to the board as a guarantee for the payment of damages in the sum of $250,000; or satisfactory proofs that the company has property subject to execution within this state, other than pipelines, of a value in excess of $250,000.

e. Exhibit E. Consent or other showing of right of appropriate public highway authorities, or railroad companies, where the pipeline will be placed longitudinally on, over or under, or at other than an approximate right angle to railroad tracks or highway, when consent is obtained prior to filing of the petition and hearing shall be filed with the petition.

If the exact and specific route is uncertain at the time of petition, a statement shall be made by petitioner that all consents or other showing of right will be obtained prior to construction and copies filed with the board.

f. Exhibit F. This exhibit shall contain the following information:

(1) A statement of the purpose of the project and a description of how the services rendered by the pipeline will promote the public convenience and necessity.

(2) A general statement covering each of the following topics: the nature of the lands, waters, and public or private facilities to be crossed; the possible use of alternative routes; the relationship of the proposed pipeline to present and future land use and zoning ordinances; and the inconvenience or undue injury which may result to property owners as a result of the proposed project.

(3) For an existing pipeline, the year of original construction and a description of any amendments or reportable changes since the permit or latest renewal permit was issued.

g. Exhibit G. If informational meetings were required, an affidavit that the meetings were held in each county affected by the proposed project and the time and place of each meeting. Copies of the mailed notice letter and the published notice(s) of the informational meeting shall be attached to the affidavit.

h. Exhibit H. This exhibit is required only if the petition requests the right of eminent domain. The extent of the eminent domain request may be uncertain at the time the petition is filed. However, the exhibit must be in final form before a hearing is scheduled. The exhibit shall consist of a map of the route showing the location of each property for which the right of eminent domain is sought and the following information for each property:

(1) The legal description of the property.

(2) The legal description of the desired easement.

(3) A specific description of the easement rights being sought.

(4) The names and addresses of the owners of record and parties in possession of the property.

(5) A map drawn to an appropriate scale showing the boundaries of the property, the boundaries and dimensions of the proposed easement, the location of pipelines or pipeline facilities within the proposed easement, the location of and distance to any building within 300 feet of the proposed pipeline, and any other features pertinent to the location of the line to the rights being sought.

i. Exhibit I. If pipeline construction on agricultural land as defined in 199—subrule 9.1(3) is proposed, a land restoration plan shall be prepared and filed as provided for in rule 199—9.2(479,479A,479B).

j. Underground storage. If permission is sought to construct, maintain and operate facilities for underground storage of gas, the petition shall include the following information, in addition to that stated above:

(1) A description of the public or private highways, grounds and waters, streams and private lands of any kind under which the storage is proposed, together with a map.

(2) Maps showing the location of proposed machinery, appliances, fixtures, wells, and stations necessary for the construction, maintenance, and operation of the facilities.

k. Other exhibits. The board may require filing of additional exhibits if further information on a particular project is deemed necessary.

13.2(2) Petitions proposing new pipeline construction on an existing easement where the company has previously constructed a pipeline shall include a statement indicating whether any unresolved damage claims remain from the previous pipeline construction and, if so, shall include the name of each landowner or tenant, a legal description of the property involved, and the status of proceedings to settle the claim.

A petition for permit proposing a new pipeline construction on an existing easement where the company has previously constructed a pipeline will not be acted upon by the board if a damage claim from the installation of its previous pipeline has not been determined by negotiation, arbitration, or court action. This paragraph will not apply if the damage claim is under litigation or arbitration.

13.2(3) Statement of damage claims.

a. A petition for permit proposing new pipeline construction will not be acted upon by the board if the company does not have on file with the board a written statement as to how damages resulting from the construction of the pipeline shall be determined and paid.

The statement shall contain the following information: the type of damages which will be compensated, how the amount of damages will be determined, the procedures by which disputes may be resolved, and the manner of payment.

The statement shall be amended as necessary to reflect changes in the law, company policy, or the needs of a specific project.

b. A copy of this statement shall be mailed with the notice of informational meeting as provided for in Iowa Code section 479B.4. If no informational meeting is required, a copy shall be provided to each affected party prior to entering into negotiations for payment of damages.

c. Nothing in this rule shall prevent a party from negotiating with the company for terms which are different, more specific, or in addition to the statement filed with the board.

13.2(4) Existing pipelines. Petitions for permit for pipelines in operation on July 1, 1995, shall be made in accordance with Iowa Code section 479B.4.

This rule is intended to implement Iowa Code sections 479B.4, 479B.5, 479B.13, 479B.16, and 479B.26.

199—13.3(479B) Informational meetings. Informational meetings shall be held for any proposed pipeline project over five miles in length, including both the current project and future anticipated extensions, and which is to be operated at a pressure of over 150 pounds per square inch. A separate informational meeting shall be held in each county in which real property or rights therein would be affected. Informational meetings shall be held not less than 30 days nor more than two years prior to the filing of the petition for pipeline permit and shall comply with the following:

13.3(1) *Facilities.* Prospective petitioners for a permit shall be responsible for all negotiations and compensation for a suitable facility to be used for each informational meeting, including but not limited to a building or facility which is in substantial compliance with the requirements of the Americans with Disabilities Act Accessibility Guidelines, Chapter 4, where such a building or facility is reasonably available.

13.3(2) *Location.* The informational meeting location shall be reasonably accessible to all persons, companies or corporations which may be affected by the granting of a permit.

13.3(3) *Route deviation.* Prospective petitioners desiring a route corridor to permit minor route deviations beyond the proposed permanent right-of-way width shall include as affected all parties within the desired corridor. Prospective petitioners may also provide notice to affected parties on alternative route corridors.

13.3(4) *Notices.* Announcement by mailed and published notice of the meeting shall be given to affected parties of interest in real estate. Affected parties of interest in real estate are those persons, companies or corporations listed on the tax assessment rolls as responsible for payment of real estate taxes and parties in possession of or residing on the property over which the prospective petitioner will seek easements.

a. The meeting notice shall state the name of the prospective petitioner; state the address of the prospective petitioner's principal place of business; state the general description and purpose of the proposed project; state the general nature of the right-of-way desired; include a map showing the proposed route; advise that the affected party has the right to be present at the informational meeting and to file objections with the board; contain the following statement: "Persons with disabilities requiring assistive services or devices to observe or participate should contact the Utilities Board at (515)725-7300 in advance of the scheduled date to request that appropriate arrangements be made"; and designate the date, time, and place of the meeting. Mailed notices shall also include a copy of the statement of damage claims as required by 13.2(3)*"b."*

b. The prospective petitioner shall cause a written copy of the meeting notice to be served, by certified United States mail with return receipt requested, on all affected parties whose addresses are known. The certified meeting notice shall be deposited in the U.S. mails not less than 30 days prior to the date of the meeting.

c. The prospective petitioner shall cause the meeting notice, including the map, to be published once in a newspaper of general circulation in the county at least one week and not more than three weeks prior to the date of the meeting. Publication shall be considered as notice to affected parties whose residence is not known provided a good faith effort to notify can be demonstrated by the pipeline company.

13.3(5) *Personnel.* The prospective petitioner shall provide qualified personnel to speak for it in matters relating to the following:

a. The purpose of and need for the proposed project.

b. When the pipeline will be constructed.

c. In general terms, the elements involved in pipeline construction.

d. In general terms, the rights which the prospective petitioner will seek to acquire through easements.

e. Procedures to be followed in contacting affected parties for specific negotiations in acquiring voluntary easements.

f. Methods and factors used in arriving at an offered price for voluntary easements including the range of cash amount for each component.

g. Manner in which voluntary easement payments are made, including discussion of conditional easements, signing fees and time of payment.

h. Other factors or damages not included in the easement for which compensation is made, including features of interest to affected parties but not limited to computation of amounts and manner of payment.

13.3(6) *Coordinating with board.* The date, time, and location of the informational meeting shall be selected after consultation with the board to allow for scheduling of presiding officers.

This rule is intended to implement Iowa Code section 479B.4.
[Editorial change: IAC Supplement 12/29/10]

199—13.4(479B) Notice of hearing.

13.4(1) When a proper petition for permit is received by the board, it shall be docketed for hearing and the petitioner shall be advised of the time and place of hearing, except as provided for in rule 13.8(479B). Petitioner shall also be furnished copies of the official notice of hearing which petitioner shall cause to be published once each week for two consecutive weeks in a newspaper of general circulation in each county in or through which construction is proposed. The second publication shall be not less than 10 nor more than 30 days prior to the date of the hearing. Proof of publication shall be filed prior to or at the hearing.

The published notice shall include a map showing either the pipeline route or the area affected by underground gas storage, or a telephone number and an address through which interested persons can obtain a copy of a map from petitioner at no charge. If a map other than that filed as Exhibit B will be published or provided, a copy shall be filed with the petition.

13.4(2) If a petition for permit seeks the right of eminent domain, petitioner shall, in addition to the published notice of hearing, serve a copy of the notice of hearing to the owners and parties in possession of lands over which eminent domain is sought. A copy of the Exhibit H filed with the board for the affected property shall accompany the notice. Service shall be by certified United States mail, return receipt requested, addressed to their last-known address; and this notice shall be mailed not later than the first day of publication of the official notice of hearing on the petition. Not less than five days prior to the date of the hearing, the petitioner shall file with the board a certificate of service showing all addresses to which notice was sent by certified mail and the date of the mailing.

13.4(3) If a petition does not seek the right of eminent domain, but all required interests in private property have not yet been obtained, a copy of the notice of hearing shall be served upon the owners and parties in possession of those lands. Service shall be by ordinary mail, addressed to the last-known address, mailed not later than the first day of publication of the official notice. A copy of each letter of notification, or one copy of the letter accompanied by a written statement listing all parties to which it was mailed and the date of mailing, shall be filed with the board not less than five days prior to the hearing.

199—13.5(479B) Objections. A person, including a governmental entity, whose rights or interests may be affected by the object of a petition may file a written objection. The written objection shall be filed with the secretary of the board not less than five days prior to date of hearing. The board may, for good cause shown, permit filing of objections less than five days prior to hearing, but in such event petitioner shall be granted a reasonable time to meet objections.

199—13.6(479B) Hearing. Hearing shall be not less than 10 or more than 30 days from the date of last publication of notice of hearing.

Petitioner shall be represented by one or more duly authorized representatives or counsel or both. The board may examine the proposed route of the pipeline or location of the underground storage facilities which are the object of the petition or may cause examination to be made on its behalf by an engineer of its selection. One or more members of the board or a duly appointed administrative law judge shall consider the petition and any objections filed thereto and may hear testimony deemed appropriate. One or more petitions may be considered at the same hearing. Petitions may be consolidated. Hearing shall be held in the office of the board or at any other place within the state of Iowa as the board may designate. Any hearing permitted by these rules in which there are no objections, interventions or material issues in dispute may be conducted by telephonic means. Notice of the telephonic hearings shall be given to parties within a reasonable time prior to the date of hearing.

199—13.7(479B) Pipeline permit. If after hearing and appropriate findings of fact it is determined a permit should be granted, a permit shall be issued. Otherwise, the petition shall be dismissed with or without prejudice. Where proposed construction has not been established definitely, the permit will be issued on the route or location as set forth in the petition, subject to deviation of up to 660 feet (one-eighth mile) on either side of the proposed route. If the proposed construction is not completed within two years from the date of issue, subject to extension at the discretion of the board, the permit shall be void and of no further force or effect. Upon completion of the proposed construction, maps accurately showing the final routing of the pipeline shall be filed with the board.

A permit shall normally expire 25 years from date of issue. No permit shall be granted for a period longer than 25 years.

199—13.8(479B) Renewal permits. A petition for renewal of permit may be filed at any time subsequent to issuance of a permit and prior to expiration. The petition shall be made on the form prescribed by the board. Instructions for the petition are included as a part of the form. The procedure for petition for permit shall be followed with respect to publication of notice, objections, and assessment of costs. If review of the petition finds unresolved issues of fact or law, or if an objection is filed within 20 days of the second publication of the published notice, the matter will be set for hearing. If a hearing is not required, a renewal permit will be issued upon the filing of the proof of publication required by subrule 13.4(1). Renewal permits shall normally expire 25 years from date of issue. No permit shall be granted for a period longer than 25 years. The same procedure shall be followed for subsequent renewals.

This rule is intended to implement Iowa Code sections 476.2 and 479B.14.

199—13.9(479B) Amendment of permits.

13.9(1) An amendment of pipeline permit by the board is required in any of the following circumstances:

a. Construction of a pipeline paralleling an existing line of petitioner;

b. Extension of an existing pipeline of petitioner by more than 660 feet (one-eighth mile);

c. Relocation of an existing pipeline of petitioner which:

(1) Relocates the pipeline more than 660 feet (one-eighth mile) from the route approved by the board; or

(2) Involves relocation requiring new or additional interests in property for five miles or more of pipe to be operated at over 150 psig. Informational meetings as provided for by rule 199—13.3(479B) shall be held for these relocations.

d. Contiguous extension of an underground storage area of petitioner; or

e. Modification of any condition or limitation placed on the construction or operation of the pipeline in the final order granting the pipeline permit.

13.9(2) Petition for amendment. The petition for amendment shall include the docket number and issue date of the permit for which amendment is sought and shall clearly state the purpose of the petition. If the petition is for construction of additional pipeline facilities or expansion of an underground storage area, the same exhibits as required for a petition for permit shall be attached.

The applicable procedures for petition for permit, including hearing, shall be followed. Upon appropriate determination by the board, an amendment to a permit will be issued. The amendment shall be subject to the same conditions with respect to completion of construction within two years and the filing of final routing maps as attached to a permit.

199—13.10(479B) Fees and expenses. The petitioner shall pay the actual unrecovered cost incurred by the board attributable to the processing, investigation, and inspection related to a petition requesting a pipeline permit action.

Any moneys collected by the board from other sources for chargeable activities will be deducted from billings for actual expenses submitted to the petitioner.

199—13.11 Reserved.

199—13.12(479B) Land restoration. Pipelines shall be constructed in compliance with 199 IAC Chapter 9, "Restoration of Agricultural Lands During and After Pipeline Construction."

199—13.13 Reserved.

199—13.14(479B) Crossings of highways, railroads, and rivers.

13.14(1) Iowa Code chapter 479B gives the Iowa utilities board primary authority over the routing of pipelines. However, highway and railroad authorities and environmental agencies may have a jurisdictional interest in the routing of the pipeline, including requirements that permits or other authorizations be obtained prior to construction for crossings of highway or railroad right-of-way, or rivers or other bodies of water.

Except for other than approximate right angle crossings of highway or railroad right-of-way, the approval of other authorities need not be obtained prior to petitioning the board for a pipeline permit. It is recommended the appropriate other authorities be contacted well in advance of construction to determine what restrictions or conditions may be placed on the crossing, and to obtain information on any proposed reconstruction or relocation of existing facilities which may impact the routing of the pipeline.

13.14(2) Pipeline routes which include crossings of highway or railroad right-of-way at other than an approximate right angle, or longitudinally on the right-of-way, shall not be constructed unless a showing of consent by the appropriate authority has been provided by the petitioner as required in paragraph 13.2(1)*"e."*

199—13.15 to **13.17** Reserved.

199—13.18(479B) Reportable changes to pipelines under permit.

13.18(1) The board shall receive prior notice of any of the following actions affecting a pipeline under permit:

a. Abandonment or removal from service.

b. Relocation of more than 300 feet from the original alignment, or any relocation that would bring the pipeline to within 300 feet of an occupied residence. Relocations of 660 feet (one-eighth mile) or more shall require the filing of a petition for amendment of a permit.

c. Change in product being transported.

d. Replacement of a pipeline or significant portion thereof, not including short repair sections of pipe at least as strong as the original pipe.

e. Extensions of existing pipelines by 660 feet (one-eighth mile) or less.

13.18(2) The notice shall include the docket and permit numbers of the pipeline, the location involved, a description of the proposed activity, anticipated dates of commencement and completion, revised maps and facility descriptions, where appropriate, and the name and telephone number of a person to contact for additional information.

199—13.19(479B) Sale or transfer of permit.

13.19(1) No permit shall be sold without prior written approval of the board. A petition for approval shall be jointly filed by the buyer and seller and shall include assurances that the buyer is authorized to transact business in the state of Iowa; that the buyer is willing and able to construct, operate, and maintain the pipeline in accordance with these rules; and, if the sale is prior to completion of construction of the pipeline, that the buyer has the financial ability to pay up to $250,000 in damages.

13.19(2) No transfer of pipeline permit prior to completion of pipeline construction shall be effective until the person to whom the permit was issued files notice with the board of the transfer. The notice shall include the date of the transfer and the name and address of the transferee.

13.19(3) The board shall receive notice from the transferor of any other transfer of a pipeline permit after completion of construction.

For the purposes of this rule, reassignment of a pipeline permit as part of a corporate restructuring, with no change in pipeline operating personnel or procedures, is considered a transfer.

199—13.20(479B) Amendments to rules. Rescinded IAB 6/25/03, effective 7/30/03.

These rules are intended to implement Iowa Code chapter 479B.

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CHAPTER 19
SERVICE SUPPLIED BY GAS UTILITIES
[Prior to 10/8/86, Commerce Commission [250]]

199—19.1(476) General information.

19.1(1) *Authorization of rules.* Iowa Code chapter 476 provides that the Iowa utilities board shall establish all needful, just and reasonable rules, not inconsistent with law, to govern the exercise of its powers and duties, the practice and procedure before it, and to govern the form, contents and filing of reports, documents and other papers necessary to carry out the provisions of this law.

Iowa Code chapter 479 provides that the Iowa utilities board shall have full authority and power to promulgate rules as it deems proper and expedient in the supervision of the transportation or transmission and underground storage of gas within the state of Iowa.

The application of the rules in this chapter to municipally owned utilities furnishing gas is limited by Iowa Code section 476.1B.

19.1(2) *Application of rules.* The rules shall apply to any gas utility operating within the state of Iowa as defined in Iowa Code chapter 476 and shall supersede any tariff on file with this board which is in conflict with these rules. These rules are intended to promote safe and adequate service to the public, to provide standards for uniform and reasonable practices by utilities, and to establish a basis for determining the reasonableness of such demands as may be made by the public upon the utilities. A request to waive the application of any rule on a permanent or temporary basis may be made in accordance with rule 199—1.3(17A,474,476,78GA,HF2206). The adoption of these rules shall in no way preclude the board from altering or amending them, pursuant to statute, or from making such modifications with respect to their application as may be found necessary to meet exceptional conditions. These regulations shall in no way relieve any utility from any of its duties under the laws of this state.

19.1(3) *Definitions.* The following words and terms, when used in these rules shall have the meaning indicated below:

The abbreviations used, and their meanings, are as follows:

Btu—British thermal unit

LP-Gas—Liquefied Petroleum Gas

psig—Pounds per Square Inch, Gauge

W.C.—Water Column

"Appliance" refers to any device which utilizes gas fuel to produce light, heat or power.

"Board" means the Iowa utilities board.

"Complaint" as used in these rules is a statement or question by anyone, whether a utility customer or not, alleging a wrong, grievance, injury, dissatisfaction, illegal action or procedure, dangerous condition or action, or utility failure to fulfill an obligation.

"Cubic foot" of gas has the following meanings:

1. Where gas is supplied and metered to customers at the pressure (as defined in 19.7(2)) normally used for domestic customers' appliances, a cubic foot of gas shall be that quantity of gas which, at the temperature and pressure existing in the meter, occupies one cubic foot, except that where a temperature compensated meter is used, the temperature base shall be 60°F.

2. When gas is supplied to customers at other than the pressure in (1) above, the utility shall specify in its rules the base for measurement of a cubic foot of gas (see 19.2(4)*"c"*(6)). Unless otherwise stated by the utility, such cubic foot of gas shall be that quantity of gas which, at a temperature of 60°F and a pressure of 14.73 pounds per square inch absolute, occupies one cubic foot.

3. The standard cubic foot of gas for testing the gas itself for heating value shall be that quantity of gas, saturated with water vapor, which, at a temperature of 60°F and a pressure of 30 inches of mercury, occupies one cubic foot. (Temperature of mercury = 32°F acceleration due to gravity = 32.17 ft. per second per second density = 13.595 grams per cubic centimeter.)

"Customer" means any person, firm, association, or corporation, any agency of the federal, state or local government, or legal entity responsible by law for payment for the gas service or heat from the gas utility.

"Delinquent" or *"delinquency"* means an account for which a service bill or service payment agreement has not been paid in full on or before the last day for timely payment.

"Gas," unless otherwise specifically designated, means manufactured gas, natural gas, other hydrocarbon gases, or any mixture of gases produced, transmitted, distributed or furnished by any gas utility.

"Gas plant" means all facilities including all real estate, fixtures and property owned, controlled, operated or managed by a gas utility for the production, storage, transmission and distribution of gas and heat.

"Heating and calorific values." The following values shall be used:

1. *"British thermal unit"* (Btu) is the quantity of heat that must be added to one avoirdupois pound of pure water to raise its temperature from 58.5°F to 59.5°F under standard pressure.

2. *"Dry calorific value"* of a gas (total or net) is the value of the total or the net calorific value of the gas divided by the volume of dry gas in a standard cubic foot.

NOTE: The amount of dry gas in a standard cubic foot is .9826 cubic foot.

3. *"Net calorific value"* of a gas is the number of British thermal units evolved by the complete combustion, at constant pressure, of one standard cubic foot of gas with air, the temperature of the gas, air, and products of combustion being 60°F and all water formed by the combustion reaction remaining in the vapor state.

NOTE: The net calorific value of a gas is its total calorific value minus the latent heat of evaporation at standard temperature of the water formed by the combustion reaction.

4. *"Therm"* means 100,000 British thermal units.

5. *"Total calorific value"* of a gas is the number of British thermal units evolved by the complete combustion, at constant pressure, of one standard cubic foot of gas with air, the temperature of the gas, air and products of combustion being 60°F and all water formed by the combustion reaction condensed to the liquid state.

"Interruption of service" means any disturbance of the gas supply whereby gas service to a customer cannot be maintained.

"Loss factor" as used in rule 199—19.10(476) means test-year purchases less test-year sales. A five-year average of purchases less sales may be used if the test year is determined by the board to be abnormal.

"Main" means a gas pipe, owned, operated, or maintained by a utility, which is used for the purpose of transmission or distribution of gas, but does not include "service line".

"Meter," without other qualification, shall mean any device or instrument which is used by a utility in measuring a quantity of gas.

"Meter shop" is a shop where meters are inspected, repaired and tested, and may be at a fixed location or may be mobile.

"Pressure," unless otherwise stated, is expressed in pounds per square inch above atmospheric pressure, i.e., gauge pressure (abbreviation-psig).

"Rate-regulated utility" means any utility as defined in the definition of "utility" below which is subject to rate regulation provided for in Iowa Code chapter 476.

"Service line" means a distribution line that transports gas from a common source of supply to a customer meter or the connection to a customer's piping, whichever is farther downstream, or the connection to a customer's piping if there is not a customer meter. A customer meter is the meter that measures the transfer of gas from a utility to a customer.

"Tap" or *"town border station"* means the delivery point or measuring station at which a gas distribution utility receives gas from a natural gas transmission company.

"Tariff" means the entire body of rates, tolls, rentals, charges, classifications, rules, procedures, policies, etc., adopted and filed with the board by a gas utility in fulfilling its role of furnishing gas service.

"Timely payment" is a payment on a customer's account made on or before the date shown on a current bill for service or on a form which records an agreement between the customer and a utility for

a series of partial payments to settle a delinquent account, as the date which determines application of a late payment charge to the current bill or future collection efforts.

"Utility" means any person, partnership, business association, or corporation, domestic or foreign, owning or operating any facilities for furnishing gas or heat to the public for compensation.

199—19.2(476) Records, reports, and tariffs.

19.2(1) *Location and retention of records.* Unless otherwise specified in this chapter, all records required by these rules shall be kept and preserved in accordance with the applicable provisions of Chapter 18 of the board's rules, Utility Records.

19.2(2) *Tariffs to be filed with the board.* The schedules of rates and rules of rate-regulated gas utilities shall be filed with the board and shall be classified, designated, arranged and submitted so as to conform to the requirements of this chapter. Provisions of the schedules shall be definite and so stated as to minimize ambiguity or the possibility of misinterpretation. The form, identification and content of tariffs shall be in accordance with these rules.

Utilities which are not subject to the rate regulation provided for by Iowa Code chapter 476 shall not be required to file schedules of rates, rules, or contracts primarily concerned with a rate schedule with the board, but nothing contained in these rules shall be deemed to relieve any utility of the requirement of furnishing any of these same schedules or contracts which are needed by the board in the performance of the board's duties upon request to do so by the board.

19.2(3) *Form and identification.* All tariffs shall conform to the following rules:

a. The tariff shall be printed, typewritten or otherwise reproduced on 8½- × 11- inch sheets of durable white paper so as to result in a clear and permanent record. The sheets of the tariff should be ruled or spaced to set off a border on the left side suitable for binding. In the case of utilities subject to regulation by any federal agency the format of sheets of tariff as filed with the board may be the same format as is required by the federal agency provided that the rules of the board as to title page; identity of superseding, replacing or revision sheets; identity of amending sheets; identity of the filing utility, issuing official, date of issue, effective date; and the words, "Gas Tariff Filed with Board" shall apply in the modification of the federal agency format for the purposes of filing with this board.

b. The title page of every tariff and supplement shall show:

(1) The first page shall be the title page which shall show:

(Name of Public Utility)
Gas Tariff
Filed with
Iowa Utilities Board

(date)

(This requirement does not apply to tariffs or amendments filed with the board prior to April 1, 1982.)

(2) When a tariff is to be superseded or replaced in its entirety, the replacing tariff shall show on the upper right corner of its title page that it is a revision of a tariff on file and the number being superseded or replaced, for example:

Tariff No. _____
Supersedes Tariff No. _____

(This requirement does not apply to tariffs or amendments filed with the board prior to April 1, 1982.)

(3) When a new part of a tariff eliminates an existing part of a tariff it shall so state and clearly identify the part eliminated.

(4) Any tariff modifications as defined in "3" above replacing tariff sheets shall be marked in the right margin with symbols as herein described to indicate the place, nature and extent of the change in text.

Symbol	*Meaning*
(C)	A change in regulation
(D)	A discontinued rate, treatment or regulation
(I)	An increased rate or new treatment resulting in increased rate
(N)	A new rate, treatment or regulation
(R)	A reduced rate or new treatment resulting in a reduced rate
(T)	A change in text but no change in rate, treatment or regulation

c. All sheets except the title page shall have, in addition to the above-stated requirements, the following information:

(1) Name of utility under which shall be set forth the words "Filed with Board." If the utility is not a corporation, and a trade name is used, the name of the individual or partners must precede the trade name.

(2) Issuing official and issue date.

(3) Effective date (to be left blank by rate-regulated utilities).

d. All sheets except the title page shall have the following form:

(Company Name)	(Part identification)
Gas Tariff	(This sheet identification)
Filed with board	(Canceled sheet identification, if any)
(Content of tariff)	
Issued: (Date)	Effective:
Issued by: (Name, title)	(Proposed Effective Date:)

The issued date is the date the tariff or the amended sheet content was adopted by the utility.

The effective date will be left blank by rate-regulated utilities and shall be determined by the board. The utility may propose an effective date.

19.2(4) *Content of tariffs.* A tariff filed with the board shall contain:

a. A table of contents containing a list of rate schedules and other sections in the order in which they appear showing the sheet number of the first page of each section.

b. All rates of utilities subject to rate regulation for service with indication of each rate for the type of gas and the class of customers to which each rate applies. There shall also be shown the prices per unit of service, the number of units per billing period to which the prices apply, the period of billing, the minimum bill, the method of measuring demands and consumptions, including the method of calculating or estimating loads or minimums, delivery pressure, and any special terms or conditions applicable. All rates should be separated into "gas" and "nongas" components, and books and records shall be maintained on this basis. Books and records shall be available to the board for audits upon request. The gas components will be the result of the utility's periodic review of gas procurement practices rule (199—19.11(476)) and PGA (rule 199—19.10(476)) proceeding. The nongas components will be established through rate case proceedings under Iowa Code section 476.3 or 476.6. The period during which the net amount may be paid before the account becomes delinquent shall be specified. In any case where net and gross amounts are billed, the difference between net and gross is a late payment charge and shall be so specified.

Customer charges for all special services relating to providing the basic utility service including, but not limited to, reconnect charge and different categories of service calls shall be specified.

c. A copy of the utility's rules, or terms and conditions, describing the utility's policies and practices in rendering service shall include:

(1) A statement as to the equivalent total heating value of the gas in Btu's per cubic foot on which their customers are billed. If necessary, this may be listed by district, division or community.

(2) The list of the items which the utility furnishes, owns, and maintains on the customer's premises, such as service pipe, meters, regulators, vents and shut-off valves.

(3) General statement indicating the extent to which the utility will provide service in the adjustment of customer appliances at no additional customer charge.

(4) General statement of the utility's policy in making adjustments for wastage of gas when such wastage occurs without the knowledge of the customer.

(5) A statement indicating the minimum number of days allowed for payment after the due date of the customer's bill before service will be discontinued for nonpayment.

(6) A statement indicating the volumetric measurement base to which all sales of gas at other than standard delivery pressure are corrected.

(7) Forms of standard contracts required of customers for the various types of service available.

(8) All tariffs must provide that, notwithstanding any other provision of this tariff or contract with reference thereto, all rates and charges contained in this tariff or contract with reference thereto may be modified at any time by a subsequent filing made pursuant to the provisions of Iowa Code chapter 476.

(9) A copy of each type of customer bill.

(10) Definitions of classes of customer.

(11) Rules for extending service in accordance with 19.3(10).

(12) Rules with which prospective customers must comply as a condition of receiving service, and the terms of contracts required.

(13) Rules governing the establishment and maintenance of credit by customers for payment of service bills.

(14) Rules governing disconnecting and reconnecting service.

(15) Notice required from customer for having service discontinued.

(16) Rules covering temporary, emergency, auxiliary, and stand-by service.

(17) Rules shall show any limitations on loads and cover the type of equipment which may or may not be connected.

(18) Rate-regulated utilities shall include a list of service areas and the applicable rates in such form as to facilitate ready determination of the rates available in each municipality and in such unincorporated communities as have service.

(19) Rules on meter reading, billing periods, bill issuance, timely customer payment, notice of delinquency and service disconnection for nonpayment of bill.

(20) Rules on how a customer or prospective customer should file a complaint with the utility, and how the complaint will be processed.

(21) Rules on how a customer, disconnected customer or potential customer for residential service may negotiate for a payment agreement on amount due, determination of even payment amounts, and time allowed for payments.

(22) If a sliding scale or automatic adjustment is applicable to regulated rates or charges of billed customers, the manner and method of such adjustment calculation shall be covered through a detailed explanation.

19.2(5) *Annual, periodic and other reports to be filed with the board.*

a. System map verification. A utility shall file annually with the board a verification that it has a correct set of utility system maps for each operating or distribution area. The maps shall show:

(1) Peak shaving facilities location.

(2) Feeder and distribution mains indicating size and pressure.

(3) System metering (town border stations and other supply points).

(4) Regulator stations in system indicating inlet and outlet pressures.

(5) Calorimeter location.

(6) State boundary crossing.

(7) Franchise area.

(8) Names of all communities (post offices) served.

b. Incident reports. Rescinded IAB 1/30/08, effective 3/5/08.

c. Construction programs. Rescinded IAB 11/19/97, effective 12/24/97.

d. Reports of gas service. Each utility shall compile a monthly record of gas service. The record shall be completed within 30 days after the end of the month covered. The compilation is to be kept

available, for inspection by the board or its staff, at the utility's principal office within the state of Iowa. Such record shall contain:

(1) The daily and monthly average of total heating values of gas in accordance with 19.7(6).

(2) The monthly acquisition and disposition of gas.

(3) Interruptions of service occurring during the month in accordance with 19.7(7). If there were no interruptions, then it should be so stated.

(4) The number of customer pressure investigations made and the results.

(5) The number of customer meters tested and test results tabulated as follows: The number that falls into limits 0 to + 2%, + 2 to + 4%, 0 to - 2%, - 2 to - 4%, over + 4%, under - 4%, and "Does Not Register" in accuracy.

(6) Progress on leak survey programs including the number of leaks found classified as to hazard and nature, and if known, the cause and type of pipe involved.

(7) Number of district regulators checked and nature of repairs required.

(8) Number of house regulators checked and nature of repairs required.

(9) Description of any unusual operating difficulties.

(10) Type of odorant and monthly average pounds per million cubic feet used in each individual distribution system.

A summary of the 12 monthly gas service records for each calendar year shall be attached to and submitted with the utility's annual fiscal plant and statistical report to the board.

e. Filing published meter and service installation rules. A copy of the utility's current rules, if any, published or furnished by the utility for the use of engineers, architects, plumbing contractors, etc., covering meter and service installation shall be filed with the board.

f. Filing customer bill forms. A copy of each type of customer bill form in current use shall be filed with the board.

g. Reports to federal agencies. Copies of reports submitted pursuant to 49 CFR Part 191 as amended through August 19, 2009, "Transportation of Natural and Other Gas by Pipeline; Annual Reports, Incident Reports, and Safety-Related Condition Reports," shall be filed with the board. Utilities operating in other states shall provide to the board data for Iowa only.

h. Change in rate. A notification to the board shall be made of any planned change in rate of service by a utility even though the change in rate of service is provided for in its tariff filing with the board. This information shall reflect the amount of increase or decrease and the effective date of application. An up-to-date tariff sheet shall be supplied to the Iowa utilities board for its copy of the tariff showing the current rates.

i. List of persons authorized to receive board inquiries. Each utility shall file with the board in the annual report required by 199—subrule 23.1(2) a list of names, titles, addresses, and telephone numbers of persons authorized to receive, act upon, and respond to communications from the board in connection with: (1) general management duties; (2) customer relations (complaints); (3) engineering operations; (4) meter tests and repairs; (5) pipeline permits (gas). Each utility shall file with the board a telephone contact number or numbers where the board can obtain current information 24 hours a day about incidents and interruptions of service from a knowledgeable person. The contact information required by this paragraph shall be kept current as changes or corrections are made.

j. Residential customer statistics. Each rate-regulated gas utility shall file with the board on or before the fifteenth day of each month one copy of the following residential customer statistics for the preceding month:

(1) Number of accounts;

(2) Number of accounts certified as eligible for energy assistance since the preceding October 1;

(3) Number of accounts past due;

(4) Number of accounts eligible for energy assistance and past due;

(5) Total revenue owed on accounts past due;

(6) Total revenue owed on accounts eligible for energy assistance and past due;

(7) Number of disconnection notices issued;

(8) Number of disconnection notices issued on accounts eligible for energy assistance;

(9) Number of disconnections for nonpayment;

(10) Number of reconnections;

(11) Number of accounts determined uncollectible; and

(12) Number of accounts eligible for energy assistance and determined uncollectible.

k. Monthly, periodic and annual reports. Each utility shall file such other monthly, periodic and annual reports as are requested by the board. Monthly and periodic reports shall be due in the board's office within 30 days after the end of the reporting period. All annual reports shall be filed with this board by April 1 of each year for the preceding calendar year.

This rule is intended to implement Iowa Code section 476.2.

[**ARC 7962B**, IAB 7/15/09, effective 8/19/09]

199—19.3(476) General service requirements.

19.3(1) *Disposition of gas.* The meter and any service line pressure regulator shall be owned by the utility. The utility shall place a visible seal on all meters and service line regulators in customer use, such that the seal must be broken to gain entry.

a. All gas sold by a utility shall be on the basis of meter measurement except:

(1) Where the consumption of gas may be readily computed without metering; or

(2) For temporary service installations.

b. The amount of all gas delivered to multioccupancy premises within a single building, where units are separately rented or owned, shall be measured on the basis of individual meter measurement for each unit, except in the following instances:

(1) Where gas is used in centralized heating, cooling or water-heating systems;

(2) Where a facility is designated for elderly or handicapped persons;

(3) Where submetering or resale of service was permitted prior to 1966; or

(4) Where individual metering is impractical. "Impractical" means: (1) where conditions or structural barriers exist in the multioccupancy building that would make individual meters unsafe or physically impossible to install; (2) where the cost of providing individual metering exceeds the long-term benefits of individual metering; or (3) where the benefits of individual metering (reduced and controlled energy consumption) are more effectively accomplished through a master meter arrangement.

If a multioccupancy building is master-metered, the end-user occupants may be charged for natural gas as an unidentified portion of the rent, condominium fee, or similar payment, or, if some other method of allocating the cost of the gas service is used, the total charge for gas service shall not exceed the total gas bill charged by the utility for the same period.

c. Master metering to multiple buildings is prohibited, except for multiple buildings owned by the same person or entity. Multioccupancy premises within a multiple building complex may be master-metered pursuant to this paragraph only if the requirements of paragraph 19.3(1)*"b"* have been met.

d. For purposes of this subrule, a "master meter" means a single meter used in determining the amount of natural gas provided to a multioccupancy building or multiple buildings.

e. This rule shall not be construed to prohibit any utility from requiring more extensive individual metering than otherwise required by this rule if pursuant to tariffs filed with and approved by the board.

f. All gas consumed by the utility shall be on the basis of meter measurement except where consumption may be readily computed without metering or where metering is impractical.

19.3(2) *Condition of meter.* Rescinded IAB 11/12/03, effective 12/17/03. See 199 IAC 19.6(7).

19.3(3) *Meter reading records.* The meter reading records shall show:

a. Customer's name, address, rate schedule, or identification of rate schedule.

b. Identifying number or description of the meter(s).

c. Meter readings.

d. If the reading has been estimated.

e. Any applicable multiplier or constant, or reference thereto.

19.3(4) *Meter charts.* All charts taken from recording meters shall be marked with the initial and final date and hour of the record, the meter identification, customer's name and location and the chart multiplier.

19.3(5) *Meter register.* If it is necessary to apply a multiplier to the meter readings, the multiplier must be marked on the face of the meter register or stenciled in weather resistant paint upon the front cover of the meter. Where remote meter reading is used, whether outdoor on-premises or off-premises-automated, the customers shall have a readable meter register at the meter as a means of verifying the accuracy of bills presented to them.

19.3(6) *Prepayment meters.* Prepayment meters shall not be geared or set so as to result in the charge of a rate or amount higher than would be paid if a standard type meter were used, except under such special rate schedule as may be filed under 19.2(4).

19.3(7) *Meter reading and billing interval.* Readings of all meters used for determining charges and billings to customers shall be scheduled at least monthly and for the beginning and termination of service. Bills to larger customers may, for good cause, be rendered weekly or daily for a period not to exceed one month. Intervals other than monthly shall not be applied to smaller customers, or to larger customers after the initial month provided above, without an exemption from the board. A waiver request must include the information required by 199—1.3(17A,474,476,78GA,HF2206). If the board denies a waiver, or if a waiver is not sought with respect to a large volume customer after the initial month, that customer's bill shall be rendered monthly for the next 12 months, unless prior approval is received from the board for a shorter interval. The group of larger customers to which shorter billing intervals may be applied shall be specified in the utility's tariff sheets, but shall not include residential customers.

An effort shall be made to obtain readings of the meters on corresponding days of each meter-reading period. The utility rules may permit the customer to supply the meter readings by telephone or on a form supplied by the utility. The utility may arrange for customer meter reading forms to be delivered to the utility by United States mail, electronically, or by hand delivery. Unless the utility has a plan to test check meter readings, a utility representative shall physically read the meter at least once each 12 months and when the utility is notified there is a change of customer.

The utility may arrange for the meter to be read by electronic means. Unless the utility has a plan to test check electronic meter readings, a utility representative shall physically read the meter at least once every 12 months.

19.3(8) *Readings and estimates.* When a customer is connected or disconnected or the meter reading date causes a given billing period to deviate by more than 10 percent (counting only business days) from the normal meter reading period, such bill shall be prorated on a daily basis.

When access to meters cannot be gained, the utility may leave with the customer a meter reading form. The customer may provide the meter reading by telephone, electronic mail (if it is allowed by the utility), or by mail. If the meter reading information is not returned in time for the billing operation, an estimated bill may be rendered. If an actual meter reading cannot be obtained, the utility may render an estimated bill without reading the meter or supplying a meter reading form to the customer. Only in unusual cases or when approval is obtained from the customer shall more than three consecutive estimated bills be rendered.

The utility shall incorporate normalized weather data in its calculation of an estimated bill.

Utilities shall file with the board their procedures for calculating estimated bills, including their procedures for determining the reasonable degree-day data to use in the calculations. Utilities shall inform the board when changes are made to the procedures for calculating estimated bills.

19.3(9) *Temporary service.* When the utility renders a temporary service to a customer it may require that the customer bear all the cost of installing and removing the service in excess of any salvage realized.

19.3(10) *Plant additions, distribution main extensions, and service lines.*

a. Definitions. The following definitions shall apply to the terms as used in this subrule.

"Advance for construction," as used in this subrule, means cash payments or equivalent surety made to the utility by an applicant for an extensive plant addition or a distribution main extension, portions of which may be refunded depending on any subsequent service line attached to the extensive plant addition or distribution main extension. Cash payments or equivalent surety shall include a grossed-up amount

for the income tax effect of such revenue. The amount of tax shall be reduced by the present value of the tax benefits to be obtained by depreciating the property in determining the tax liability.

"Agreed-upon attachment period," as used in this subrule, means a period of not less than 30 days nor more than one year mutually agreed upon by the utility and the applicant within which the customer will attach. If no time period is mutually agreed upon, the agreed-upon attachment period shall be deemed to be 30 days.

"Contribution in aid of construction," as used in this subrule, means a nonrefundable cash payment grossed-up for the income tax effect of such revenue covering the costs of a distribution main extension or service line that are in excess of costs paid by the utility. The amount of tax shall be reduced by the present value of the tax benefits to be obtained by depreciating the property in determining the tax liability.

"Distribution main extension," as used in this subrule, means a segment of pipeline installed to convey gas to individual service lines or other distribution mains.

"Estimated annual revenues," as used in this subrule, shall be calculated based upon the following factors, including, but not limited to: The size of the facility to be used by the customer, the size and type of equipment to be used by the customer, the average annual amount of service required by the equipment, and the average number of hours per day and days per year the equipment will be in use.

"Estimated base revenues," as used in this subrule, shall be calculated by subtracting the cost of purchased gas and energy efficiency charges from estimated annual revenues.

"Estimated construction costs," as used in this subrule, shall be calculated using average current costs in accordance with good engineering practices and upon the following factors: amount of service required or desired by the customer requesting the distribution main extension or service line; size, location, and characteristics of the distribution main extension or service line, including appurtenances; and whether the ground is frozen or whether other adverse conditions exist. In no event shall estimated construction costs include costs associated with facilities built for the convenience of the utility. The customer shall be charged actual permit fees in addition to estimated construction costs. Permit fees are to be paid regardless of whether the customer is required to pay an advance for construction or a nonrefundable contribution in aid of construction, and the cost of any permit fee is not refundable.

"Plant addition," as used in this subrule, means any additional plant, other than a distribution main or service line, required to be constructed to provide service to a customer.

"Service line," as used in this subrule, means the piping that extends from the distribution main to the meter set riser.

"Similarly situated customer," as used in this subrule, means a customer whose annual consumption or service requirements, as defined by estimated annual revenue, are approximately the same as the annual consumption or service requirements of other customers.

"Utility," as used in this subrule, means a rate-regulated utility.

b. Plant additions. The utility shall provide all gas plant at its cost and expense without requiring an advance for construction from customers or developers except in those unusual circumstances where extensive plant additions are required before the customer can be served. A written contract between the utility and the customer which requires an advance for construction by the customer to make plant additions shall be available for board inspection.

c. Distribution main extensions. Where the customer will attach to the distribution main extension within the agreed-upon attachment period after completion of the distribution main extension, the following shall apply:

(1) The utility shall finance and make the distribution main extension for a customer without requiring an advance for construction if the estimated construction costs to provide a distribution main extension are less than or equal to three times estimated base revenue calculated on the basis of similarly situated customers. The utility may use a feasibility model, rather than three times estimated base revenue, to determine what, if any, advance for construction is required of the customer. The utility shall file a summary explaining the inputs into the feasibility model and a description of the model as part of the utility's tariff. Whether or not the construction of the distribution main extension would

otherwise require a payment from a customer, the utility shall charge the customer for actual permit fees, and the permit fees are not refundable.

(2) If the estimated construction cost to provide a distribution main extension is greater than three times estimated base revenue calculated on the basis of similarly situated customers, the applicant for a distribution main extension shall contract with the utility and make, no more than 30 days prior to commencement of construction, an advance for construction equal to the estimated construction cost less three times estimated base revenue to be produced by the customer. The utility may use a feasibility model to determine whether an advance for construction is required. The utility shall file a summary explaining the inputs into the feasibility model and a description of the model as part of the utility's tariff. A written contract between the utility and the customer shall be available for board inspection upon request. Whether or not the construction of the distribution main extension would otherwise require a payment from the customer, the utility shall charge the customer for actual permit fees, and the permit fees are not refundable.

(3) Where the customer will not attach within the agreed-upon attachment period after completion of the distribution main extension, the applicant for the distribution main extension shall contract with the utility and make, no more than 30 days prior to the commencement of construction, an advance for construction equal to the estimated construction cost. The utility may use a feasibility model to determine the amount of the advance for construction. The utility shall file a summary explaining the inputs into the feasibility model and a description of the model as part of the utility's tariff. A written contract between the utility and the customer shall be available for board inspection upon request. Whether or not the construction of the distribution main extension would otherwise require a payment from the customer, the utility shall charge the customer for actual permit fees, and the permit fees are not refundable.

(4) Advances for construction may be paid by cash or equivalent surety and shall be refundable for ten years. The customer has the option of providing an advance for construction by cash or equivalent surety unless the utility determines that the customer has failed to comply with the conditions of a surety in the past.

(5) Refunds. When the customer is required to make an advance for construction, the utility shall refund to the depositor for a period of ten years from the date of the original advance a pro-rata share for each service line attached to the distribution main extension. The pro-rata refund shall be computed in the following manner:

1. If the combined total of three times estimated base revenue, or the amount allowed by the feasibility model, for the distribution main extension and each service line attached to the distribution main extension exceeds the total estimated construction cost to provide the distribution main extension, the entire amount of the advance for construction shall be refunded.

2. If the combined total of three times estimated base revenue, or the amount allowed by the feasibility model, for the distribution main extension and each service line attached to the distribution main extension is less than the total estimated construction cost to provide the distribution main extension, the amount to be refunded shall equal three times estimated base revenue, or the amount allowed by the feasibility model, when a service line is attached to the distribution main extension.

3. In no event shall the total amount to be refunded exceed the amount of the advance for construction. Any amounts subject to refund shall be paid by the utility without interest. At the expiration of the above-described ten-year period, the advance for construction record shall be closed and the remaining balance shall be credited to the respective plant account.

(6) The utility shall keep a record of each work order under which the distribution main extension was installed, to include the estimated revenues, the estimated construction costs, the amount of any payment received, and any refunds paid.

d. Service lines.

(1) The utility shall finance and construct a service line without requiring a nonrefundable contribution in aid of construction or any payment by the applicant where the length of the service line to the riser is up to 50 feet on private property or 100 feet on private property if polyethylene plastic pipe is used.

(2) Where the length of the service line exceeds 50 feet on private property or 100 feet if polyethylene plastic pipe is used, the applicant shall be required to provide a nonrefundable contribution in aid of construction, within 30 days after completion, for that portion of the service line on private property, exclusive of the riser, in excess of 50 feet or in excess of 100 feet if polyethylene plastic pipe is used. The nonrefundable contribution in aid of construction for that portion of the service line shall be computed as follows:

(Estimated Construction Costs) ×

$$\frac{\text{(Total Length in Excess of 50 Feet) or (Total Length in Excess of 100 Feet)}}{\text{(Total Length of Service Line)}}$$

(3) A utility may adopt a tariff or rule that allows the utility to finance and construct a service line of more than 50 feet, or 100 feet if polyethylene plastic pipe is used, without requiring a nonrefundable contribution in aid of construction from the customer if the tariff or rule applies equally to all customers.

(4) Whether or not the construction of the service line would otherwise require a payment from the customer, the utility shall charge the customer for actual permit fees.

e. Extensions not required. Utilities shall not be required to make distribution main extensions or attach service lines as described in this subrule, unless the distribution main extension or service line shall be of a permanent nature.

f. Different payment arrangement. This subrule shall not be construed as prohibiting any utility from making a contract with a customer using a different payment arrangement, if the contract provides a more favorable payment arrangement to the customer, so long as no discrimination is practiced among customers.

19.3(11) *Cooperation and advance notice.* In order that full benefit may be derived from this chapter and in order to facilitate its proper application, all utilities shall observe the following cooperative practices:

a. Every utility shall give to other public utilities in the same general territory advance notice of any construction or change in construction or in operating conditions of its facilities concerned or likely to be concerned in situations of proximity, provided, however, that the requirements of this chapter shall not apply to routine extensions or minor changes in the local underground distribution facilities.

b. Every utility shall assist in promoting conformity with this chapter. An arrangement should be set up among all utilities whose facilities may occupy the same general territory, providing for the interchange of pertinent data and information including that relative to proposed and existing construction and changes in operating conditions concerned or likely to be concerned in situations of proximity.

This rule is intended to implement 42 U.S.C.A. §8372, 10 CFR 516.30, and Iowa Code section 476.8.
[**ARC 7584B**, IAB 2/25/09, effective 4/1/09]

199—19.4(476) Customer relations.

19.4(1) *Customer information.* Each utility shall:

a. Maintain up-to-date maps, plans or records of its entire transmission and distribution systems, with such other information as may be necessary to enable the utility to advise prospective customers, and others entitled to the information, as to the facilities available for serving customers in its service area.

b. Assist the customer or prospective customer in selecting the most economical rate schedule available for the proposed type of service.

c. Notify customers affected by a change in rates or schedule classification in the manner provided in the rules of practice and procedure before the board. (199—7.4(476))

d. Post a notice in a conspicuous place in each office of the utility where applications for service are received, informing the public that copies of the rate schedules and rules relating to the service of the utility, as filed with the board, are available for public inspection. If the utility provides access to its rate schedules and rules for service on its Web site, the notice should include the Web site address.

e. Upon request, inform its customers as to the method of reading meters.

f. State, on the bill form, that tariff and rate schedule information is available upon request at the utility's local business office.

g. Upon request, transmit a statement of either the customer's actual consumption, or degree day adjusted consumption, at the company's option, of natural gas for each billing period during the prior 12 months.

h. Furnish such additional information as the customer may reasonably request.

i. Promptly and courteously resolve inquiries for information or complaints. Employees who receive customer telephone calls and office visits shall be qualified and trained in screening and resolving complaints, to avoid a preliminary recitation of the entire complaint to employees without ability and authority to act. The employee shall provide identification to the customer that will enable the customer to reach that employee again if needed.

Each utility shall notify its customers, by bill insert or notice on the bill form, of the address and telephone number where a utility representative qualified to assist in resolving the complaint can be reached. The bill insert or notice shall also include the following statement: "If (utility name) does not resolve your complaint, you may request assistance from the Iowa Utilities Board by calling (515)725-7321 or toll-free 1-877-565-4450, or by writing to 1375 E. Court Avenue, Room 69, Des Moines, Iowa 50319-0069, or by E-mail to customer@iub.iowa.gov."

The bill insert or notice for municipal utilities shall include the following statement: "If your complaint is related to service disconnection, safety, or renewable energy, and (utility name) does not resolve your complaint, you may request assistance from the Iowa Utilities Board by calling (515)725-7321, or toll-free 1-877-565-4450, by writing to 1375 E. Court Avenue, Room 69, Des Moines, Iowa 50319-0069, or by E-mail to customer@iub.iowa.gov."

The bill insert or notice on the bill shall be provided monthly by utilities serving more than 50,000 Iowa retail customers and no less than annually by all other natural gas utilities. Any utility which does not use the standard statement described in this paragraph shall file its proposed statement in its tariff for approval. A utility that bills by postcard may place an advertisement in a local newspaper of general circulation or a customer newsletter instead of a mailing. The advertisement must be of a type size that is easily legible and conspicuous and must contain the information set forth above.

19.4(2) *Customer deposits.*

a. Each utility may require from any customer or prospective customer a deposit intended to guarantee partial payment of bills for service. Each utility shall allow a person other than the customer to pay the customer's deposit. In lieu of a cash deposit, the utility may accept the written guarantee of a surety or other responsible party as surety for an account. Upon termination of a guarantee contract, or whenever the utility deems the contract insufficient as to amount or surety, a cash deposit or a new or additional guarantee may be required for good cause upon reasonable written notice.

b. A new or additional deposit may be required from a customer when a deposit has been refunded or is found to be inadequate. Written notice shall be mailed advising the customer of any new or additional deposit requirement. The customer shall have no less than 12 days from the date of mailing to comply. The new or additional deposit shall be payable at any of the utility's business offices or local authorized agents. An appropriate receipt shall be provided. No written notice is required to be given of a deposit required as a prerequisite for commencing initial service.

c. No deposit shall be required as a condition for service other than determined by application of either credit rating or deposit calculation criteria, or both, of the filed tariff.

d. The total deposit for any residential or commercial customer for a place which has previously received service shall not be greater than the highest billing of service for one month for the place in the previous 12-month period. The deposit for any residential or commercial customer for a place which has not previously received service or for an industrial customer, shall be the customer's projected one-month usage for the place to be served as determined by the utility, or as may be reasonably required by the utility in cases involving service for short periods or special occasions.

19.4(3) *Interest on customer deposits.* Interest shall be paid by the rate-regulated utility to each customer required to make a deposit. On or after April 21, 1994, rate-regulated utilities shall compute

interest on customer deposits at 7.5 percent per annum, compounded annually. Interest for prior periods shall be computed at the rate specified by the rule in effect for the period in question. Interest shall be paid for the period beginning with the date of deposit to the date of refund or to the date that the deposit is applied to the customer's account, or to the date the customer's bill becomes permanently delinquent. The date of refund is that date on which the refund or the notice of deposit refund is forwarded to the customer's last-known address. The date a customer's bill becomes permanently delinquent, relative to an account treated as an uncollectible account, is the most recent date the account became delinquent.

19.4(4) *Customer deposit records.* Each utility shall keep records to show:

a. The name and address of each depositor.

b. The amount and date of the deposit.

c. Each transaction concerning the deposit.

19.4(5) *Customer's receipt for a deposit.* Each utility shall issue a receipt of deposit to each customer from whom a deposit is received, and shall provide means whereby a depositor may establish claim if the receipt is lost.

19.4(6) *Deposit refund.* A deposit shall be refunded after 12 consecutive months of prompt payment (which may be 11 timely payments and one automatic forgiveness of late payment), unless the utility is entitled to require a new or additional deposit. For refund purposes, the account shall be reviewed after 12 months of service following the making of the deposit and for each 12-month interval terminating on the anniversary of the deposit. However, deposits received from customers subject to the exemption provided by subrule 19.3(7), including surety deposits, may be retained by the utility until final billing. Upon termination of service, the deposit plus accumulated interest, less any unpaid utility bill of the customer, shall be reimbursed to the person who made the deposit.

19.4(7) *Unclaimed deposits.* The utility shall make a reasonable effort to return each unclaimed deposit and accrued interest after the termination of the services for which the deposit was made. The utility shall maintain a record of deposit information for at least two years or until such time as the deposit, together with accrued interest, escheats to the state pursuant to Iowa Code section 556.4, at which time the record and deposit, together with accrued interest less any lawful deductions, shall be sent to the state treasurer pursuant to Iowa Code section 556.11.

19.4(8) *Customer bill forms.* Each customer shall be informed as promptly as possible following the reading of the customer's meter, on bill form or otherwise, the following:

a. The reading of the meter at the beginning and at the end of the period for which the bill is rendered.

b. The dates on which the meter was read at the beginning and end of the billing period.

c. The number and kind of units metered.

d. The applicable rate schedule or identification of the applicable rate schedule.

e. The account balance brought forward and the amount of each net charge for rate-schedule-priced utility service, sales tax, other taxes, late payment charge, and total amount currently due. In the case of prepayment meters, the amount of money collected shall be shown.

f. The last date for timely payment shall be clearly shown and shall be not less than 20 days after the bill is rendered.

g. A distinct marking to identify an estimated bill.

h. A distinct marking to identify a minimum bill.

i. Any conversions from meter reading units to billing units, or any calculations to determine billing units from recording or other devices, or any other factors, such as sliding scale or automatic adjustment and amount of sales tax adjustments used in determining the bill.

19.4(9) *Customer billing information alternate.* A utility serving fewer than 5000 gas customers may provide the information in 19.4(8) on bill form or otherwise. If the utility elects not to provide the information of 19.4(8) on the bill form, it shall advise the customer, on the bill form or by bill insert, that such information can be obtained by contacting the utility's local office.

19.4(10) *Payment agreements.*

a. Availability of a first payment agreement. When a residential customer cannot pay in full a delinquent bill for utility service or has an outstanding debt to the utility for residential utility service and

is not in default of a payment agreement with the utility, a utility shall offer the customer an opportunity to enter into a reasonable payment agreement.

b. Reasonableness. Whether a payment agreement is reasonable will be determined by considering the current household income, ability to pay, payment history including prior defaults on similar agreements, the size of the bill, the amount of time and the reasons why the bill has been outstanding, and any special circumstances creating extreme hardships within the household. The utility may require the person to confirm financial difficulty with an acknowledgment from the department of human services or another agency.

c. Terms of payment agreements.

(1) *First payment agreement.* The utility shall offer customers who have received a disconnection notice or have been disconnected 120 days or less and who are not in default of a payment agreement the option of spreading payments evenly over at least 12 months by paying specific amounts at scheduled times. The utility shall offer customers who have been disconnected more than 120 days and who are not in default of a payment agreement the option of spreading payments evenly over at least 6 months by paying specific amounts at scheduled times.

1. The agreement shall also include provision for payment of the current account. The agreement negotiations and periodic payment terms shall comply with tariff provisions which are consistent with these rules. The utility may also require the customer to enter into a level payment plan to pay the current bill.

2. When the customer makes the agreement in person, a signed copy of the agreement shall be provided to the customer.

3. The utility may offer the customer the option of making the agreement over the telephone or through electronic transmission. When the customer makes the agreement over the telephone or through electronic transmission, the utility shall render to the customer a written document reflecting the terms and conditions of the agreement within three days of the date the parties entered into the oral agreement or electronic agreement. The document will be considered rendered to the customer when addressed to the customer's last-known address and deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the document shall be considered rendered to the customer when delivered to the last-known address of the person responsible for payment for the service. The document shall state that unless the customer notifies the utility within ten days from the date the document is rendered, it will be deemed that the customer accepts the terms as reflected in the written document. The document stating the terms and agreements shall include the address and a toll-free or collect telephone number where a qualified representative can be reached. By making the first payment, the customer confirms acceptance of the terms of the oral agreement or electronic agreement.

4. Each customer entering into a first payment agreement shall be granted at least one late payment that is made four days or less beyond the due date for payment and the first payment agreement shall remain in effect.

(2) *Second payment agreement.* The utility shall offer a second payment agreement to a customer who is in default of a first payment agreement if the customer has made at least two consecutive full payments under the first payment agreement. The second payment agreement shall be for the same term as or longer than the term of the first payment agreement. The customer shall be required to pay for current service in addition to the monthly payments under the second payment agreement and may be required to make the first payment up-front as a condition of entering into the second payment agreement. The utility may also require the customer to enter into a level payment plan to pay the current bill. The utility may offer additional payment agreements to the customer.

d. Refusal by utility. A customer may offer the utility a proposed payment agreement. If the utility and the customer do not reach an agreement, the utility may refuse the offer orally, but the utility must render a written refusal of the customer's final offer, stating the reason for the refusal, within three days of the oral notification. The written refusal shall be considered rendered to the customer when addressed to the customer's last-known address and deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the written refusal shall be considered rendered to the customer when handed

to the customer or when delivered to the last-known address of the person responsible for the payment for the service.

A customer may ask the board for assistance in working out a reasonable payment agreement. The request for assistance must be made to the board within ten days after the rendering of the written refusal. During the review of this request, the utility shall not disconnect the service.

19.4(11) *Bill payment terms.* The bill shall be considered rendered to the customer when deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the bill shall be considered rendered when delivered to the last-known address of the party responsible for payment. There shall be not less than 20 days between the rendering of a bill and the date by which the account becomes delinquent. Bills for customers on more frequent billing intervals under subrule 19.3(7) may not be considered delinquent less than 5 days from the date of rendering. However, a late payment charge may not be assessed if payment is received within 20 days of the date the bill is rendered.

a. The date of delinquency for all residential customers or other customers whose consumption is less than 250 ccf per month shall be changeable for cause in writing; such as, but not limited to, 15 days from approximate date each month upon which income is received by the person responsible for payment. In no case, however, shall the utility be required to delay the date of delinquency more than 30 days beyond the date of preparation of the previous bill.

b. In any case where net and gross amounts are billed to customers, the difference between net and gross is a late payment charge and is valid only when part of a delinquent bill payment. A utility's late payment charge shall not exceed 1.5 percent per month of the past due amount. No collection fee may be levied in addition to this late payment charge. This rule does not prohibit cost-justified charges for disconnection and reconnection of service.

c. If the customer makes partial payment in a timely manner, and does not designate the service or product for which payment is made, the payment shall be credited pro rata between the bill for utility services and related taxes.

d. Each account shall be granted not less than one complete forgiveness of a late payment charge each calendar year. The utility's rules shall be definitive that on one monthly bill in each period of eligibility, the utility will accept the net amount of such bill as full payment for such month after expiration of the net payment period. The rules shall state how the customer is notified that the eligibility has been used. Complete forgiveness prohibits any effect upon the credit rating of the customer or collection of late payment charge.

e. Level payment plan. Utilities shall offer a level payment plan to all residential customers or other customers whose consumption is less than 250 ccf per month. A level payment plan should be designed to limit the volatility of a customer's bill and maintain reasonable account balances. The level payment plan shall include at least the following:

(1) Be offered to each eligible customer when the customer initially requests service.

(2) Allow for entry into the level payment plan anytime during the calendar year.

(3) Provide that a customer may request termination of the plan at any time. If the customer's account is in arrears at the time of termination, the balance shall be due and payable at the time of termination. If there is a credit balance, the customer shall be allowed the option of obtaining a refund or applying the credit to future charges. A utility is not required to offer a new level payment plan to a customer for six months after the customer has terminated from a level payment plan.

(4) Use a computation method that produces a reasonable monthly level payment amount, which may take into account forward-looking factors such as fuel price and weather forecasts, and that complies with requirements in 19.4(11)*"e"*(4). The computation method used by the utility shall be described in the utility's tariff and shall be subject to board approval. The utility shall give notice to customers when it changes the type of computation method in the level payment plan.

The amount to be paid at each billing interval by a customer on a level payment plan shall be computed at the time of entry into the plan and shall be recomputed at least annually. The level payment amount may be recomputed monthly, quarterly, when requested by the customer, or whenever price, consumption, or a combination of factors results in a new estimate differing by 10 percent or more from that in use.

When the level payment amount is recomputed, the level payment plan account balance shall be divided by 12, and the resulting amount shall be added to the estimated monthly level payment amount. Except when a utility has a level payment plan that recomputes the level payment amount monthly, the customer shall be given the option of applying any credit to payments of subsequent months' level payment amounts due or of obtaining a refund of any credit in excess of $25.

Except when a utility has a level payment plan that recomputes the level payment amount monthly, the customer shall be notified of the recomputed payment amount not less than one full billing cycle prior to the date of delinquency for the recomputed payment. The notice may accompany the bill prior to the bill that is affected by the recomputed payment amount.

(5) Irrespective of the account balance, a delinquency in payment shall be subject to the same collection and disconnection procedures as other accounts, with the late payment charge applied to the level payment amount. If the account balance is a credit, the level payment plan may be terminated by the utility after 30 days of delinquency.

19.4(12) *Customer records.* The utility shall retain customer billing records for the length of time necessary to permit the utility to comply with 19.4(13) but not less than three years.

19.4(13) *Adjustment of bills.* Bills which are incorrect due to billing errors or faulty metering installation are to be adjusted as follows:

a. Fast metering. Whenever a metering installation is tested and found to have overregistered more than 2 percent, the utility shall recalculate the bills for service.

(1) The bills for service shall be recalculated from the time at which the error first developed or occurred if that time can be definitely determined.

(2) If the time at which the error first developed or occurred cannot be definitely determined, it shall be assumed that the overregistration has existed for the shortest time period calculated as one-half the time since the meter was installed or one-half the time elapsed since the last meter test unless otherwise ordered by the board.

(3) If the recalculated bills indicate that $5 or more is due an existing customer or $10 or more is due a person no longer a customer of the utility, the tariff shall provide for refunding of the full amount of the calculated difference between the amount paid and the recalculated amount. Refunds shall be made to the two most recent customers who received service through the metering installation during the time the error existed. In the case of a previous customer who is no longer a customer of the utility, a notice of the amount subject to refund shall be mailed to such previous customer at the last-known address, and the utility shall, upon demand made within three months thereafter, refund the same.

Refunds shall be completed within six months following the date of the metering installation test.

b. Slow metering. Whenever a meter is found to be more than 2 percent slow, the tariff may provide for back billing the customer for the amount the test indicates has been undercharged for the period of inaccuracy.

When the average error cannot be determined by test because of failure of part or all of the metering equipment, the tariff may provide for use of the registration of check metering installation, if any, or for estimating the quantity consumed based on available data. The customer must be advised of the failure and of the basis for the estimate of quantity billed.

(1) The utility may not back bill due to underregistration unless a minimum back bill amount is specified in its tariff. The minimum amount specified for back billing shall not be less than, but may be greater than, $5 for an existing customer or $10 for a former customer. All recalculations resulting in an amount due equal or greater than the tariff specified minimum shall result in issuance of a back bill.

(2) The period for back billing shall not exceed the last six months the meter was in service unless otherwise ordered by the board.

(3) Back billings shall be rendered no later than six months following the date of the metering installation test.

c. Billing adjustments due to fast or slow meters shall be calculated on the basis that the meter should be 100 percent accurate. For the purpose of billing adjustment the meter error shall be one-half of the algebraic sum of the error at full-rated flow plus the error at check flow.

d. When a customer has been overcharged as a result of incorrect reading of the meter, incorrect application of the rate schedule, incorrect connection of the meter, or other similar reasons, the amount of the overcharge shall be adjusted, refunded, or credited to the customer. The time period for which the utility is required to adjust, refund, or credit the customer's bill shall not exceed five years unless otherwise ordered by the board.

e. Undercharges. When a customer has been undercharged as a result of incorrect reading of the meter, incorrect application of the rate schedule, incorrect connection of the meter, or other similar reasons, the amount of the undercharge may be billed to the customer. The period for which the utility may adjust for the undercharge shall not exceed five years unless otherwise ordered by the board. The maximum back bill shall not exceed the dollar amount equivalent to the tariffed rate for like charges (e.g., usage-based, fixed or service charges) in the 12 months preceding discovery of the error unless otherwise ordered by the board.

19.4(14) *Credits and explanations.* Credits due a customer because of meter inaccuracies, errors in billing, or misapplication of rates shall be separately identified.

19.4(15) *Refusal or disconnection of service.* A utility shall refuse service or disconnect service to a customer, as defined in subrule 19.1(3), in accordance with tariffs that are consistent with these rules.

a. The utility shall give written notice of pending disconnection except as specified in paragraph 19.4(15)*"b."* The notice shall set forth the reason for the notice and final date by which the account is to be settled or specific action taken. The notice shall be considered rendered to the customer when addressed to the customer's last-known address and deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the notice shall be considered rendered when delivered to the last-known address of the person responsible for payment for the service. The date for disconnection of service shall be not less than 12 days after the notice is rendered. The date for disconnection of service for customers on shorter billing intervals under subrule 19.3(7) shall not be less than 24 hours after the notice is posted at the service premises.

One written notice, including all reasons for the notice, shall be given where more than one cause exists for disconnection of service. In determining the final date by which the account is to be settled or other specific action taken, the days of notice for the causes shall be concurrent.

b. Service may be disconnected without notice:

(1) In the event of a condition determined by the utility to be hazardous.

(2) In the event of customer use of equipment in a manner which adversely affects the utility's equipment or the utility's service to others.

(3) In the event of tampering with the equipment furnished and owned by the utility. For the purposes of this subrule, a broken or absent meter seal alone shall not constitute tampering.

(4) In the event of unauthorized use.

c. Service may be disconnected or refused after proper notice:

(1) For violation of or noncompliance with the utility's rules on file with the board.

(2) For failure of the customer to furnish the service equipment, permits, certificates, or rights-of-way which are specified to be furnished, in the utility's rules filed with the board, as conditions of obtaining service, or for the withdrawal of that same equipment, or for the termination of those same permissions or rights, or for the failure of the customer to fulfill the contractual obligations imposed as conditions of obtaining service by any contract filed with and subject to the regulatory authority of the board.

(3) For failure of the customer to permit the utility reasonable access to the utility's equipment.

d. Service may be refused or disconnected after proper notice for nonpayment of a bill or deposit, except as restricted by subrules 19.4(16) and 19.4(17), provided that the utility has complied with the following provisions when applicable:

(1) Given the customer a reasonable opportunity to dispute the reason for the disconnection or refusal;

(2) Given the customer, and any other person or agency designated by the customer, written notice that the customer has at least 12 days in which to make settlement of the account to avoid disconnection and a written summary of the rights and responsibilities available. Customers billed more frequently

than monthly pursuant to subrule 19.3(7) shall be given posted written notice that they have 24 hours to make settlement of the account to avoid disconnection and a written summary of the rights and responsibilities. All written notices shall include a toll-free or collect telephone number where a utility representative qualified to provide additional information about the disconnection can be reached. Each utility representative must provide the representative's name and have immediate access to current, detailed information concerning the customer's account and previous contacts with the utility.

(3) The summary of the rights and responsibilities must be approved by the board. Any utility providing gas service and defined as a public utility in Iowa Code section 476.1 which does not use the standard form set forth below for customers billed monthly shall submit to the board an original and six copies of its proposed form for approval. A utility billing a combination customer for both gas and electric service may modify the standard form to replace each use of the word "gas" with the words "gas and electric" in all instances.

CUSTOMER RIGHTS AND RESPONSIBILITIES TO AVOID SHUTOFF OF GAS SERVICE FOR NONPAYMENT

1. What can I do if I receive a notice from the utility that says my gas service will be shut off because I have a past due bill?

a. Pay the bill in full; or

b. Enter into a reasonable payment plan with the utility (see #2 below); or

c. Apply for and become eligible for low-income energy assistance (see #3 below); or

d. Give the utility a written statement from a doctor or public health official stating that shutting off your gas service would pose an especial health danger for a person living at the residence (see #4 below); or

e. Tell the utility if you think part of the amount shown on the bill is wrong. However, you must still pay the part of the bill you agree you owe the utility (see #5 below).

2. How do I go about making a reasonable payment plan? (Residential customers only)

a. Contact the utility as soon as you know you cannot pay the amount you owe. If you cannot pay all the money you owe at one time, the utility may offer you a payment plan that spreads payments evenly over at least 12 months. The plan may be longer depending on your financial situation.

b. If you have not made the payments you promised in a previous payment plan with the utility and still owe money, you may qualify for a second payment agreement under certain conditions.

c. If you do not make the payments you promise, the utility may shut off your utility service on one day's notice unless all the money you owe the utility is paid or you enter into another payment agreement.

3. How do I apply for low-income energy assistance? (Residential customers only)

a. Contact the local community action agency in your area (see attached list); or

b. Contact the Division of Community Action Agencies at the Iowa Department of Human Rights, Lucas State Office Building, Des Moines, Iowa 50319; telephone (515)281-0859. To prevent disconnection, you must contact the utility prior to disconnection of your service.

c. To avoid disconnection, you must apply for energy assistance before your service is shut off. Notify your utility that you may be eligible and have applied for energy assistance. Once your service has been disconnected, it will not be reconnected based on approval for energy assistance.

d. Being certified eligible for energy assistance will prevent your service from being disconnected from November 1 through April 1.

4. What if someone living at the residence has a serious health condition? (Residential customers only)

Contact the utility if you believe this is the case. Contact your doctor or a public health official and ask the doctor or health official to contact the utility and state that shutting off your utility service would pose an especial health danger for a person living at your residence. The doctor or public health official must provide a written statement to the utility office within 5 days of when your doctor or public health official notifies the utility of the health condition; otherwise, your utility service may be shut off. If the utility receives this written statement, your service will not be shut off for 30 days. This 30-day delay is to allow you time to arrange payment of your utility bill or find other living arrangements. After 30 days, your service may be shut off if payment arrangements have not been made.

5. What should I do if I believe my bill is not correct?

You may dispute your utility bill. You must tell the utility that you dispute the bill. You must pay the part of the bill you think is correct. If you do this, the utility will not shut off your service for 45 days from the date the bill was mailed while you and the utility work out the dispute over the part of the bill you think is incorrect. You may ask the Iowa Utilities Board for assistance in resolving the dispute. (See #9 below.)

6. When can the utility shut off my utility service because I have not paid my bill?

a. Your utility can shut off service between the hours of 6 a.m. and 2 p.m., Monday through Friday.

b. The utility will not shut off your service on nights, weekends, or holidays for nonpayment of a bill.

c. The utility will not shut off your service if you enter into a reasonable payment plan to pay the overdue amount (see #2 above).

d. The utility will not shut off your service if the temperature is forecasted to be 20 degrees Fahrenheit or colder during the following 24-hour period, including the day your service is scheduled to be shut off.

e. If you have qualified for low-income energy assistance, the utility cannot shut off your service from November 1 through April 1. However, you will still owe the utility for the service used during this time.

f. The utility will not shut off your service if you have notified the utility that you dispute a portion of your bill and you pay the part of the bill that you agree is correct.

g. If one of the heads of household is a service member deployed for military service, utility service cannot be shut off during the deployment or within 90 days after the end of deployment. In order for this exception to disconnection to apply, the utility must be informed of the deployment prior to disconnection. However, you will still owe the utility for service used during this time.

7. How will I be told the utility is going to shut off my gas service?

a. You must be given a written notice at least 12 days before the utility service can be shut off for nonpayment. This notice will include the reason for shutting off your service.

b. If you have not made payments required by an agreed-upon payment plan, your service may be disconnected with only one day's notice.

c. The utility must also try to reach you by telephone or in person before it shuts off your service. From November 1 through April 1, if the utility cannot reach you by telephone or in person, the utility will put a written notice on the door of your residence to tell you that your utility service will be shut off.

8. If service is shut off, when will it be turned back on?

a. The utility will turn your service back on if you pay the whole amount you owe or agree to a reasonable payment plan (see #2 above).

b. If you make your payment during regular business hours, or by 7 p.m. for utilities permitting such payment or other arrangements after regular business hours, the utility must make a reasonable effort to turn your service back on that day. If service cannot reasonably be turned on that same day, the utility must do it by 11 a.m. the next day.

c. The utility may charge you a fee to turn your service back on. Those fees may be higher in the evening or on weekends, so you may ask that your service be turned on during normal utility business hours.

9. Is there any other help available besides my utility?

If the utility has not been able to help you with your problem, you may contact the Iowa Utilities Board toll-free at 1-877-565-4450. You may also write the Iowa Utilities Board at 1375 E. Court Avenue, Room 69, Des Moines, Iowa 50319-0069, or by E-mail at customer@iub.iowa.gov. Low-income customers may also be eligible for free legal assistance from Iowa Legal Aid, and may contact Legal Aid at 1-800-532-1275.

(4) When disconnecting service to a residence, made a diligent attempt to contact, by telephone or in person, the customer responsible for payment for service to the residence to inform the customer of the pending disconnection and the customer's rights and responsibilities. During the period from November 1 through April 1, if the attempt at customer contact fails, the premises shall be posted at least one day

prior to disconnection with a notice informing the customer of the pending disconnection and rights and responsibilities available to avoid disconnection.

If an attempt at personal or telephone contact of a customer occupying a rental unit has been unsuccessful, the landlord of the rental unit, if known, shall be contacted to determine if the customer is still in occupancy and, if so, the customer's present location. The landlord shall also be informed of the date when service may be disconnected.

If the disconnection will affect occupants of residential units leased from the customer, the premises of any building known by the utility to contain residential units affected by disconnection must be posted, at least two days prior to disconnection, with a notice informing any occupants of the date when service will be disconnected and the reasons for the disconnection.

(5) Disputed bill. If the customer has received notice of disconnection and has a dispute concerning a bill for natural gas service, the utility may require the customer to pay a sum of money equal to the amount of the undisputed portion of the bill pending settlement and thereby avoid disconnection of service. A utility shall delay disconnection for nonpayment of the disputed bill for up to 45 days after the rendering of the bill if the customer pays the undisputed amount. The 45 days shall be extended by up to 60 days if requested of the utility by the board in the event the customer files a written complaint with the board in compliance with 199—Chapter 6.

(6) Reconnection. Disconnection of a residential customer may take place only between the hours of 6 a.m. and 2 p.m. on a weekday and not on weekends or holidays. If a disconnected customer makes payment or other arrangements during normal business hours, or by 7 p.m. for utilities permitting such payment or other arrangements after normal business hours, all reasonable efforts shall be made to reconnect the customer that day. If a disconnected customer makes payment or other arrangements after 7 p.m., all reasonable efforts shall be made to reconnect the customer not later than 11 a.m. the next day.

(7) Severe cold weather. A disconnection may not take place where gas is used as the only source of space heating or to control or operate the only space heating equipment at the residence on any day when the National Weather Service forecast for the following 24 hours covering the area in which the residence is located includes a forecast that the temperature will be 20 degrees Fahrenheit or colder. In any case where the utility has posted a disconnect notice in compliance with subparagraph 19.4(15)*"d"*(4) but is precluded from disconnecting service because of a National Weather Service forecast, the utility may immediately proceed with appropriate disconnection procedures, without further notice, when the temperature in the area where the residence is located rises above 20 degrees Fahrenheit and is forecasted to be above 20 degrees Fahrenheit for at least 24 hours, unless the customer has paid in full the past due amount or is entitled to postponement of disconnection under some other provision of paragraph 19.4(15)*"d."*

(8) Health of a resident. Disconnection of a residential customer shall be postponed if the disconnection of service would present an especial danger to the health of any permanent resident of the premises. An especial danger to health is indicated if a person appears to be seriously impaired and may, because of mental or physical problems, be unable to manage the person's own resources, to carry out activities of daily living or to be protected from neglect or hazardous situations without assistance from others. Indicators of an especial danger to health include but are not limited to: age, infirmity, or mental incapacitation; serious illness; physical disability, including blindness and limited mobility; and any other factual circumstances which indicate a severe or hazardous health situation.

The utility may require written verification of the especial danger to health by a physician or a public health official, including the name of the person endangered; a statement that the person is a resident of the premises in question; the name, business address, and telephone number of the certifying party; the nature of the health danger; and approximately how long the danger will continue. Initial verification by the verifying party may be by telephone if written verification is forwarded to the utility within five days.

Verification shall postpone disconnection for 30 days. In the event service is terminated within 14 days prior to verification of illness by or for a qualifying resident, service shall be restored to that residence if a proper verification is thereafter made in accordance with the foregoing provisions. If the customer does not enter into a reasonable payment agreement for the retirement of the unpaid balance of the account within the first 30 days and does not keep the current account paid during the period

that the unpaid balance is to be retired, the customer is subject to disconnection pursuant to paragraph 19.4(15)*"f."*

(9) Winter energy assistance (November 1 through April 1). If the utility is informed that the customer's household may qualify for winter energy assistance or weatherization funds, there shall be no disconnection of service for 30 days from the date the utility is notified to allow the customer time to obtain assistance. Disconnection shall not take place from November 1 through April 1 for a resident who is a head of household and who has been certified to the public utility by the community action agency as eligible for either the low-income home energy assistance program or weatherization assistance program.

(10) Deployment. If the utility is informed that one of the heads of household as defined in Iowa Code section 476.20 is a service member deployed for military service, as defined in Iowa Code section 29A.90, disconnection cannot take place at the residence during the deployment or prior to 90 days after the end of the deployment.

e. Abnormal gas consumption. A customer who is subject to disconnection for nonpayment of bill, and who has gas consumption which appears to the customer to be abnormally high, may request the utility to provide assistance in identifying the factors contributing to this usage pattern and to suggest remedial measures. The utility shall provide assistance by discussing patterns of gas usage which may be readily identifiable, suggesting that an energy audit be conducted, and identifying sources of energy conservation information and financial assistance which may be available to the customer.

f. A utility may disconnect gas service without the written 12-day notice for failure of the customer to comply with the terms of a payment agreement, except as provided in numbered paragraph 19.4(10)*"c"*(1)"4," provided the utility complies with the provisions of paragraph 19.4(15)*"d."*

g. The utility shall, prior to November 1, mail customers a notice describing the availability of winter energy assistance funds and the application process. The notice must be of a type size that is easily legible and conspicuous and must contain the information set out by the state agency administering the assistance program. A utility serving fewer than 25,000 customers may publish the notice in a customer newsletter in lieu of mailing. A utility serving fewer than 6,000 customers may publish the notice in an advertisement in a local newspaper of general circulation or shopper's guide.

19.4(16) *Insufficient reasons for denying service.* The following shall not constitute sufficient cause for refusal of service to a customer:

a. Delinquency in payment for service by a previous occupant of the premises to be served.

b. Failure to pay for merchandise purchased from the utility.

c. Failure to pay for a different type or class of public utility service.

d. Failure to pay the bill of another customer as guarantor thereof.

e. Failure to pay the back bill rendered in accordance with paragraph 19.4(13)*"b"* (slow meters).

f. Failure to pay adjusted bills based on the undercharges set forth in paragraph 19.4(13)*"e."*

g. Failure of a residential customer to pay a deposit during the period November 1 through April 1 for the location at which the customer has been receiving service.

h. Delinquency in payment for service by an occupant, if the customer applying for service is creditworthy and able to satisfy any deposit requirements.

19.4(17) *When disconnection prohibited.*

a. No disconnection may take place from November 1 through April 1 for a resident who is a head of household and who has been certified to the public utility by the local community action agency as being eligible for either the low-income home energy assistance program or weatherization assistance program.

b. If the utility is informed that one of the heads of household as defined in Iowa Code section 476.20 is a service member deployed for military service, as defined in Iowa Code section 29A.90, disconnection cannot take place at the residence during the deployment or prior to 90 days after the end of the deployment.

19.4(18) *Change in character of service.* The following shall apply to a material change in the character of gas service:

a. Changes under the control of the utility. The utility shall make such changes only with the approval of the board, and after adequate notice to the customers (see 19.7(6)*"a"*).

b. Changes not under control of the utility or customer. The utility shall adjust appliances to attain the proper combustion of the gas supplied. Due consideration shall be given to the gas heating value and specific gravity (see 19.7(6)*"b"*).

c. Appliance adjustment charge. The utility shall make any necessary adjustments to the customer's appliances without charge and shall conduct the adjustment program with a minimum of inconvenience to the customers.

19.4(19) *Customer complaints.* Each utility shall investigate promptly and thoroughly and keep a record of written complaints and all other reasonable complaints received by it from its customers in regard to safety, service, or rates, and the operation of its system as will enable it to review and analyze its procedures and actions. The record shall show the name and address of the complainant, the date and nature of the complaint, and its disposition and the date thereof. All complaints caused by a major outage or interruption shall be summarized in a single report.

a. Each utility shall provide in its filed tariff a concise, fully informative procedure for the resolution of customer complaints.

b. The utility shall take reasonable steps to ensure that customers unable to travel shall not be denied the right to be heard.

c. The final step in a complaint hearing and review procedure shall be a filing for board resolution of the issues.

This rule is intended to implement Iowa Code sections 476.2, 476.6, 476.8, 476.20 and 476.54.
[**ARC 9101B**, IAB 9/22/10, effective 10/27/10; Editorial change: IAC Supplement 12/29/10]

199—19.5(476) Engineering practice.

19.5(1) *Requirement for good engineering practice.* The gas plant of the utility shall be constructed, installed, maintained and operated in accordance with accepted good engineering practice in the gas industry to assure, as far as reasonably possible, continuity of service, uniformity in the quality of service furnished, and the safety of persons and property.

19.5(2) *Standards incorporated by reference.*

a. The design, construction, operation, and maintenance of gas systems and liquefied natural gas facilities shall be in accordance with the following standards where applicable:

(1) 49 CFR Part 191, "Transportation of Natural and Other Gas by Pipeline; Annual Reports, Incident Reports, and Safety-Related Condition Reports," as amended through August 19, 2009.

(2) 49 CFR Part 192, "Transportation of Natural and Other Gas by Pipeline: Minimum Federal Safety Standards," as amended through August 19, 2009.

(3) 49 CFR Part 193, "Liquefied Natural Gas Facilities: Federal Safety Standards," as amended through August 19, 2009.

(4) 49 CFR Part 199, "Drug and Alcohol Testing," as amended through August 19, 2009.

(5) ASME B31.8 - 2007, "Gas Transmission and Distribution Piping Systems."

(6) NFPA 59-2008, "Utility LP-Gas Plant Code."

(7) At railroad crossings, 199 IAC 42.7(476), "Engineering standards for pipelines."

b. The following publications are adopted as standards of accepted good practice for gas utilities:

(1) ANSI Z223.1/NFPA 54-2009, "National Fuel Gas Code."

(2) NFPA 501A-2009, "Standard for Fire Safety Criteria for Manufactured Home Installations, Sites, and Communities."

19.5(3) *Adequacy of gas supply.* The natural gas regularly available from supply sources supplemented by production or storage capacity must be sufficiently large to meet all reasonable demands for firm gas service.

19.5(4) *Gas transmission and distribution facilities.* The utility's gas transmission and distribution facilities shall be designed, constructed and maintained as required to reliably perform the gas delivery burden placed upon them. Each utility shall be capable of emergency repair work on a scale consistent with its scope of operation and with the physical conditions of its transmission and distribution facilities.

In appraising the reliability of the utility's transmission and distribution system, the board will consider, as principal factors, the condition of the physical property and the size, training, supervision, availability, equipment and mobility of the maintenance forces.

19.5(5) *Inspection of gas plant.* Each utility shall adopt a program of inspection of its gas plant in order to determine the necessity for replacement and repair. The frequency of the various inspections shall be based on the utility's experience and accepted good practice. Each utility shall keep sufficient records to give evidence of compliance with its inspection program.

[**ARC 7962B**, IAB 7/15/09, effective 8/19/09]

199—19.6(476) Metering.

19.6(1) *Inspection and testing program.* Each utility shall adopt a written program for the inspection and testing of its meters to determine the necessity for adjustment, replacement or repair. The frequency of inspection and methods of testing shall be based on the utility's experience, manufacturer's recommendations, and accepted good practice. The board considers the publications listed in 19.6(3) to be representative of accepted good practice. Each utility shall maintain inspection and testing records for each meter and associated device until three years after its retirement.

19.6(2) *Program content.* The written program shall, at minimum, address the following subject areas:

a. Classification of meters by capacity, type, and any other factor considered pertinent.

b. Checking of new meters for acceptable accuracy before being placed in service.

c. Testing of in-service meters, including any associated instruments or corrective devices, for accuracy, adjustments or repairs. This may be accomplished by periodic tests at specified intervals or on the basis of a statistical sampling plan, but shall include meters removed from service for any reason.

d. Periodic calibration or testing of devices or instruments used by the utility to test meters.

e. Leak testing of meters before return to service.

f. The limits of meter accuracy considered acceptable by the utility.

g. The nature of meter and meter test records maintained by the utility.

19.6(3) *Accepted good practice.* The following publications are considered to be representative of accepted good practice in matters of metering and meter testing:

a. American National Standard for Gas Displacement Meters (500 Cubic Feet Per Hour Capacity and Under), ANSI B109.1-2000.

b. American National Standard for Diaphragm Type Gas Displacement Meters (Over 500 Cubic Feet Per Hour Capacity), ANSI B109.2-2000.

c. American National Standard for Rotary Type Gas Displacement Meters, ANSI B109.3-2000.

d. Measurement of Gas Flow by Turbine Meters, ANSI/ASME MFC-4M-1986 (Reaffirmed 2008).

e. Orifice Metering of Natural Gas and Other Related Hydrocarbon Fluids, API MPMS Chapter 14.3, Parts 1-4.

19.6(4) *Meter adjustment.* All meters and associated metering devices shall, when tested, be adjusted as closely as practicable to the condition of zero error.

19.6(5) *Request tests.* Upon request by a customer, a utility shall test the meter servicing that customer. A test need not be made more frequently than once in 18 months.

A written report of the test results shall be mailed to the customer within ten days of the completed test and a record of each test shall be kept on file at the utility's office. The utility shall give the customer or a representative of the customer the opportunity to be present while the test is conducted.

If the test finds the meter is accurate within the limits accepted by the utility in its meter inspection and testing program, the utility may charge the customer $25 or the cost of conducting the test, whichever is less. The customer shall be advised of any potential charge before the meter is removed for testing.

19.6(6) *Referee tests.* Upon written request by a customer or utility, the board will conduct a referee test of a meter. A test need not be made more frequently than once in 18 months. The customer request shall be accompanied by a $30 deposit in the form of a check or money order made payable to the utility.

Within 5 days of receipt of the written request and payment, the board shall forward the deposit to the utility and notify the utility of the requirement for a test. The utility shall, within 30 days after notification of the request, schedule the date, time and place of the test with the board and customer. The meter shall not be removed or adjusted before the test. The utility shall furnish all testing equipment and facilities for the test. If the tested meter is found to be more than 2 percent fast or 2 percent slow, the deposit will be returned to the party requesting the test and billing adjustments shall be made as required in 19.4(13). The board shall issue its report within 15 days after the test is conducted, with a copy to the customer and the utility.

19.6(7) *Condition of meter.* No meter that is known to be mechanically defective, has an incorrect correction factor, or has not been tested and adjusted, if necessary, in accordance with 19.6(2)*"b," "c,"* and *"e,"* shall be installed or continued in service. The capacity of the meter and the index mechanism shall be consistent with the gas requirements of the customer.
[**ARC 7962B**, IAB 7/15/09, effective 8/19/09]

199—19.7(476) Standards of quality of service.

19.7(1) *Purity requirements.* All gas supplied to customers shall be substantially free of impurities which may cause corrosion of mains or piping or from corrosive or harmful fumes when burned in a properly designed and adjusted burner.

19.7(2) *Pressure limits.* The maximum allowable operating pressure for a low-pressure distribution system shall not be so high as to cause the unsafe operation of any connected and properly adjusted low-pressure gas-burning equipment.

19.7(3) *Adequacy for pressure.* Each utility shall have a substantially accurate knowledge of the pressures inside its piping. Periodic pressure measurements shall be taken during periods of high demand at remote locations in distribution systems to determine the adequacy of service. Records of such measurements including the date, time, and location of the measurement shall be maintained not less than two years.

19.7(4) *Standards for pressure measurements.*

a. Secondary standards. Each utility shall own or have access to a dead weight tester. This instrument must be maintained in an accurate condition.

b. Working standards. Each utility must have or have access to water manometers, laboratory quality indicating pressure gauges, and field-type dead weight pressure gauges as necessary for the proper testing of the indicating and recording pressure gauges used in determining the pressure on the utility's system. Working standards must be checked periodically by comparison with a secondary standard.

19.7(5) *Handling of standards.* Extreme care must be exercised in the handling of standards to ensure that their accuracy is not disturbed. Each standard shall be accompanied at all times by a certificate or calibration card, duly signed and dated, on which are recorded the corrections required to compensate for errors found at the customary test points at the time of the last previous test.

19.7(6) *Heating value.*

a. Awareness. Each utility shall have a substantially accurate knowledge of the heating value of the gas being delivered to customers at all times.

b. Natural and LP-gas. The heating value of natural gas and undiluted, commercially pure LP-gas shall be considered as being not under the control of the utility. The utility shall determine the allowable range of monthly average heating values within which its customers' appliances may be expected to function properly without repeated readjustment of the burners. If the monthly average heating value is above or below the limits of the allowable range for three successive months, the customers' appliances must be readjusted in accordance with 19.4(18)*"c."*

c. Peak shaving or other mixed gas. The heating value of gas in a distribution system which includes gas from LP or LNG peak shaving facilities, or gas from a source other than a pipeline supplier, shall be considered within the control of the utility. The average daily heating value of mixed gas shall be at least 95 percent of that normally delivered by the pipeline supplier. All mixed gas shall have a specific gravity of less than 1.000, and heating value shall not be so high as to cause improper operation of properly adjusted customer equipment.

d. Heating value determination and records. Unless acceptable heating value information is available for all periods from other sources, including the pipeline supplier, the utility shall provide and maintain equipment, or shall have a method of computation, by which the heating value of the gas in a distribution system can be accurately determined. The type, accuracy, operation and location of equipment, and the accuracy of computation methods, shall be in accordance with accepted industry practices and equipment manufacturer's recommendations and shall be subject to review by the board.

19.7(7) *Interruptions of service.*

a. Each utility shall make reasonable efforts to avoid interruptions of service, but when interruptions occur, service shall be reestablished within the shortest time practicable, consistent with safety. Each utility shall maintain records for not less than two years of interruptions of service as required to be reported in 19.17(1) and shall periodically review these records to determine steps to be taken to prevent recurrence.

b. Planned interruptions shall be made at a time that will not cause unreasonable inconvenience to customers. Interruptions shall be preceded by adequate notice to those who will be affected.

199—19.8(476) Safety.

19.8(1) *Acceptable standards.* As criteria of accepted good safety practice the board will use the applicable provisions of the standard listed in 19.5(2).

19.8(2) *Protective measures.* Each utility shall exercise reasonable care to reduce hazards inherent in connection with utility service to which its employees, its customers, and the general public may be subjected and shall adopt and execute a safety program designed to protect the public, fitted to the size and type of its operations. The utility shall give reasonable assistance to the board in the investigation of the cause of accidents and in the determination of suitable means of preventing accidents. Each utility shall maintain a summary of all reportable accidents arising from its operations.

19.8(3) *Turning on gas.* Each utility upon the installation of a meter and turning on gas or the act of turning on gas alone shall take the necessary steps to assure itself that there exists no flow of gas through the meter which is a warning that the customer's piping or appliances are not safe for gas turn on (Ref: Sec. 8.2.3 and Annex D, ANSI Z223.1/NFPA 54-2009).

19.8(4) *Gas leaks.* A report of a gas leak shall be considered as an emergency requiring immediate attention.

19.8(5) *Odorization.* Any gas distributed to customers through gas mains or gas services or used for domestic purposes in compressor plants, which does not naturally possess a distinctive odor to the extent that its presence in the atmosphere is readily detectable at all gas concentrations of one-fifth of the lower explosive limit and above, shall have an odorant added to it to make it so detectable. Odorization is not necessary, however, for such gas as is delivered for further processing or use where the odorant would serve no useful purpose as a warning agent. Suitable tests must be made to determine whether the odor meets the standards of subrule 19.5(2). Prompt remedial action shall be taken if odorization levels do not meet the prescribed limits for detectability.

19.8(6) *Burial near electric lines.* Each pipeline shall be installed with at least 12 inches of clearance from buried electrical conductors. If this clearance cannot be maintained, protection from damage or introduction of current from an electrical fault shall be provided by other means.

[**ARC 7962B**, IAB 7/15/09, effective 8/19/09]

199—19.9(476) Energy conservation strategies. Rescinded IAB 11/12/03, effective 12/7/03.

199—19.10(476) Purchased gas adjustment (PGA).

19.10(1) *Purchased gas adjustment clause.* Purchased gas adjustments shall be computed separately for each customer classification or grouping previously approved by the board. Purchased gas adjustments shall use the same unit of measure as the utility's tariffed rates. Purchased gas adjustments shall be calculated using factors filed in annual or periodic filings according to the following formula:

$$PGA = \frac{(C \times Rc) + (D \times Rd) + (Z \times Rz)}{S} + Rb + E$$

PGA is the purchased gas adjustment per unit.

S is the anticipated yearly gas commodity sales volume for each customer classification or grouping.

C is the volume of applicable commodity purchased or transported for each customer classification or grouping required to meet sales, S, plus the expected lost and unaccounted for volumes.

Rc is the weighted average of applicable commodity prices or rates, including appropriate hedging tools costs, to be in effect September 1 corresponding to purchases C.

D is the total volume of applicable entitlement reservation purchases required to meet sales, S, for each customer classification or grouping.

Rd is the weighted average of applicable entitlement reservation charges to be in effect September 1 corresponding to purchases D.

Z is the total quantity of applicable storage service purchases required to meet sales, S, for each customer classification or grouping.

Rz is the weighted average of applicable storage service rates to be in effect September 1 corresponding to purchases Z.

Rb is the adjusted amount necessary to obtain the anticipated balance for the remaining PGA year calculated by taking the anticipated PGA balance divided by the forecasted volumes, including storage, for one or more months of the remaining PGA year.

E is the per unit overcollection or undercollection adjustment as calculated under subrule 19.10(7).

The components of the formula shall be determined as follows for each customer classification or grouping:

a. The actual sales volumes S for the prior 12-month period ending May 31, with the necessary degree-day adjustments, and further adjustments approved by the board.

Unless a utility receives prior board approval to use another methodology, a utility shall use the same weather normalization methodology used in prior approved PGA and rate case.

b. The annual expected lost and unaccounted for factors shall be calculated by determining the actual difference between sales and purchase volumes for the 12 months ending May 31 or from the current annual IG-1 filing, but in no case will this factor be less than 0.

c. The purchases C, D, and Z which will be necessary to meet requirements as determined in 19.10(1).

d. The purchased gas adjustments shall be adjusted prospectively to reflect the final decision issued by the board in a periodic review proceeding.

19.10(2) *Annual purchased gas adjustment filing.* Each rate-regulated utility shall file on or before August 1 of each year, for the board's approval, a purchased gas adjustment for the 12-month period beginning September 1 of that year.

The annual filing shall restate each factor of the formula stated in subrule 19.10(1).

The annual filing shall be based on customer classifications and groupings previously approved by the board unless new classifications or groupings are proposed.

The annual filing shall include all worksheets and detailed supporting data used to determine the purchased gas adjustment volumes and factors. The utility shall provide an explanation of the calculations of each factor. Information already on file with the board may be incorporated by reference in the filing.

19.10(3) *Periodic changes to purchased gas adjustment clause.* Periodic purchased gas adjustment filings shall be based on the purchased gas adjustment customer classifications and groupings previously approved by the board. Changes in the customer classification and grouping on file are not automatic and require prior approval by the board.

Periodic filings shall include all worksheets and detailed supporting data used to determine the amount of the adjustment.

Changes in factors S or C may not be made in periodic purchased gas filings. A change in factor D or Z may be made in periodic filings and will be deemed approved if it conforms to the annual purchased gas filing or if it conforms to the principles set out in 19.10(6).

The utility shall implement automatically all purchased gas adjustment changes which result from changes in Rc, Rd, or Rz with concurrent board notification with adequate information to calculate and

support the change. The purchased gas adjustment shall be calculated separately for each customer classification or grouping.

Unless otherwise ordered by the board, a rate-regulated utility's purchased gas adjustment rate factors shall be adjusted as purchased gas costs change and shall recover from the customers only the actual costs of purchased gas and other currently incurred charges associated with the delivery, inventory, or reservation of natural gas. Such periodic changes shall become effective with usage on or after the date of change.

19.10(4) *Factor Rb.* Each utility has the option of filing an Rb calculation with its October-January PGA filings but shall file an Rb calculation with its February filing and subsequent monthly filings in the PGA year. If the anticipated PGA balance represents costs in excess of revenues, factor Rb shall be assigned a positive value; if the anticipated balance represents revenues in excess of costs, factor Rb shall be assigned a negative value.

19.10(5) *Take-or-pay adjustment.* Rescinded IAB 11/12/03, effective 12/17/03.

19.10(6) *Allocations of changes in contract pipeline transportation capacity obligations.* Any change in contractual pipeline transportation capacity obligations to transportation or storage service providers serving Iowa must be reported to the board within 30 days of receipt. The change must be applied on a pro-rata basis to all customer classifications or groupings, unless another method has been approved by the board. Where a change has been granted as a result of the utility's request based on the needs of specified customers, that change may be allocated to the specified customers. Where the board has approved anticipated sales levels for one or more customer classifications or groupings, those levels may limit the pro-rata reduction for those classifications or groupings.

19.10(7) *Reconciliation of underbillings and overbillings.* The utility shall file with the board on or before October 1 of each year a purchased gas adjustment reconciliation for the 12-month period which began on September 1 of the previous year. This reconciliation shall be the actual net invoiced costs of purchased gas and appropriate financial hedging tools costs less the actual revenue billed through its purchased gas adjustment clause net of the prior year's reconciliation dollars for each customer classification or grouping. Actual net costs for purchased gas shall be the applicable invoice costs from all appropriate sources associated with the time period of usage.

Negative differences in the reconciliation shall be considered overbilling by the utility and positive differences shall be considered underbilling. This reconciliation shall be filed with all worksheets and detailed supporting data for each particular purchased gas adjustment clause. Penalty purchases shall only be includable where the utility clearly demonstrates a net savings.

a. The annual reconciliation filing shall include the following information concerning the hedging tools used by the utility:

(1) The type and volume of physical gas being hedged.

(2) The reason the hedge was undertaken (e.g., to hedge storage gas, a floating price contract).

(3) A detailed explanation of the hedging strategy (e.g., costless collar, straddled costless collar, purchasing or selling options).

(4) The date the futures contract or option was purchased or the date the swap was entered into.

(5) The spot price of gas at the time the hedge was made, including an explanation of how the spot price was determined including the index or indices used.

(6) The amount of all commissions paid and to whom those payments were made.

(7) All administrative costs associated with the hedge.

(8) The name(s) of all marketers used and the amount of money paid to each marketer.

(9) The amount of savings or costs resulting from the hedge.

(10) The amount of money tied up in margin accounts for futures trading and the cost of that money.

(11) The premium paid for each option.

(12) The strike price of each option.

(13) The contracting costs for each swap transaction.

(14) The name of the fixed-price payer in a swap transaction.

(15) A statement as to how the hedge is consistent with the LDC's natural gas procurement plan.

(16) An explanation as to why the LDC believes the hedge was in the best interest of general system customers.

(17) All invoices, work papers, and internal reports associated with the hedge.

b. Any underbilling determined from the reconciliation shall be collected through ten-month adjustments to the appropriate purchased gas adjustment. The underbilling generated from each purchased gas adjustment clause shall be divided by the anticipated sales volumes for the prospective ten-month period beginning November 1 (based upon the sales determination in subrule 19.10(1)).

The quotient, determined on the same basis as the utility's tariff rates, shall be added to the purchased gas adjustment for the prospective ten-month period beginning November 1.

c. Any overbilling determined from the reconciliation shall be refunded to the customer classification or grouping from which it was generated. The overbilling shall be divided by the annual cost of purchased gas subject to recovery for the 12-month period which began the prior September 1 for each purchased gas adjustment clause and applied as follows:

(1) If the net overbilling from the purchased gas adjustment reconciliation exceeds 3 percent of the annual cost of purchased gas subject to recovery for a specific customer classification or grouping, the utility shall refund the overbilling by bill credit or check starting on the first day of billing in the November billing cycle of the current year. The minimum amount to be refunded by check shall be $10. Interest shall be calculated on amounts exceeding 3 percent from the PGA year midpoint to the date of refunding. The interest rate shall be the dealer commercial paper rate (90-day, high-grade unsecured notes) quoted in the "Money Rates" section of the Wall Street Journal on the last working day of August of the current year.

(2) If the net overbilling from the purchased gas adjustment reconciliation does not exceed 3 percent of the annual cost of purchased gas subject to recovery for a specific customer classification or grouping, the utility may refund the overbilling by bill credit or check starting on the first day of billing in the November billing cycle of the current year, or the utility may refund the overbilling through ten-month adjustments to the particular purchased gas adjustment from which they were generated. The minimum amount to be refunded by check shall be $10. This adjustment shall be determined by dividing the overcollection by the anticipated sales volume for the prospective ten-month period beginning November 1 as determined in subrule 19.10(1) for the applicable purchased gas adjustment clause. The quotient, determined on the same basis as the utility's tariff rates, shall be a reduction to that particular purchased gas adjustment for the prospective ten-month period beginning November 1.

d. When a customer has reduced or terminated system supply service and is receiving transportation service, any liability for overcollections and undercollections shall be determined in accordance with the utility's gas transportation tariff.

19.10(8) *Refunds related to gas costs charged through the PGA.* The utility shall file a refund plan with the board within 30 days of the receipt of any refund related to gas costs charged through the PGA.

a. The utility shall refund to customers by bill credit or check an amount equal to any refund, plus accrued interest, if the refund exceeds $10 per average residential customer under the applicable customer classification or grouping. The utility may refund lesser amounts through the applicable customer classification or grouping or retain undistributed refund amounts in special refund retention accounts for each customer classification or grouping under the applicable PGA clause until such time as additional refund obligations or interest cause the average residential customer refund to exceed $10. Any obligations remaining in the retention accounts on September 1 shall become a part of the annual PGA reconciliation.

b. The utility shall file with the refund plan the following information:

(1) A statement of reason for the refund.

(2) The amount of the refund with support for the amount.

(3) The balance of the appropriate refund retention accounts.

(4) The amount due under each customer classification or grouping.

(5) The intended period of the refund distribution.

(6) The estimated interest accrued for each refund through the proposed refund period, with complete interest calculations and supporting data as determined in paragraph 19.10(8)*"d."*

(7) The total amount to be refunded, the amount to be refunded per customer classification or grouping, and the refund per ccf or therm.

(8) The estimated interest accrued for each refund received and for each amount in the refund retention accounts through the date of the filing with the complete interest calculation and support as determined in paragraph 19.10(8)*"d."*

(9) The total amount to be retained, the amount to be retained per customer classification or grouping, and the level per ccf or therm.

(10) The calculations demonstrating that the retained balance is less than $10 per average residential customer with supporting schedules for all factors used.

c. The refund to each customer shall be determined by dividing the amount in the appropriate refund retention account, including interest, by the total ccf or therm of system gas consumed by affected customers during the period for which the refundable amounts are applicable and multiplying the quotient by the ccf or therms of system supply gas actually consumed by the customer during the appropriate period. The utility may use the last available 12-month period if the use of the actual period generating the refund is impractical. The utility shall file complete support documentation for all figures used.

d. The interest rate on refunds distributed under this subrule, compounded annually, shall be the dealer commercial paper rate (90-day, high-grade unsecured notes) quoted in the "Money Rates" section of the Wall Street Journal on the day the refund obligation vests. Interest shall accrue from the date the rate-regulated utility receives the refund or billing from the supplier or the midpoint of the first month of overcollection to the date the refund is distributed to customers.

e. The rate-regulated utility shall make a reasonable effort to forward refunds, by check, to eligible recipients who are no longer customers.

f. The minimum amount to be refunded by check shall be $5.

This rule is intended to implement Iowa Code section 476.6(11).

199—19.11(476) Periodic review of gas procurement practices [476.6(15)].

19.11(1) *Procurement plan.* The board shall periodically conduct a contested case proceeding for the purpose of evaluating the reasonableness and prudence of a rate-regulated public utility's natural gas procurement and contracting practices. The board shall provide the utilities 90 days' notice of the requirement to file a procurement plan. In the years in which the board does not conduct a contested case proceeding, the board may require the utilities to file certain information for the board's review. In years in which the board conducts a full proceeding, a rate-regulated utility shall file prepared direct testimony and exhibits in support of a detailed 12-month plan and a 3-year natural gas procurement plan. A utility's procurement plan shall be organized as follows and shall include:

a. An index of all documents and information filed in the plan and identification of the board files in which documents incorporated by reference are located.

b. All contracts and gas supply arrangements executed or in effect for obtaining gas and all supply arrangements planned for the future 12-month and 3-year periods.

c. An organizational description of the officer or division responsible for gas procurement and a summary of operating procedures and policies for procuring and evaluating gas contracts.

d. A summary of the legal and regulatory actions taken to minimize purchased gas costs.

e. All studies or investigation reports considered in gas purchase contract or arrangement decisions during the plan periods.

f. A complete list of all contracts executed since the last procurement review.

g. A list of other unbundled services available (for example, storage services if offered).

h. A description of the supply options selected and an evaluation of the reasonableness and prudence of its decisions. This evaluation should show the relationship between forecast and procurement.

19.11(2) *Gas requirement forecast.* Rescinded IAB 4/3/91, effective 3/15/91.

19.11(3) *Annual review proceeding.* Rescinded IAB 2/9/00, effective 3/15/00.

19.11(4) *Evaluation of the plan.* The burden shall be on the utility to prove it is taking all reasonable actions to minimize its purchased gas costs. The board will evaluate the reasonableness and prudence of the gas procurement plan.

19.11(5) *Disallowance of costs.* The board shall disallow any purchased gas costs in excess of costs incurred under responsible and prudent policies and practices. The PGA factor shall be adjusted prospectively to reflect the disallowance.

19.11(6) *Executive summary.* On or before August 1, 2003, each natural gas utility shall file an executive summary and index of all standard and special contracts in effect for the purchase, sale or interchange of gas. On or before August 1 each year thereafter, each natural gas utility shall file an update of the executive summary and index showing the standard and special contracts in effect on that date for the purchase, sale or interchange of gas. The executive summary shall include the following information:

a. The contract number;

b. The start and end date;

c. The parties to the contract;

d. The total estimated dollar value of the contract;

e. A description of the type of service offered (including volumes and price).

This rule is intended to implement Iowa Code section 476.6(15).

199—19.12(476) Flexible rates.

19.12(1) *Purpose.* This subrule is intended to allow gas utility companies to offer, at their option, incentive or discount rates to their sales and transportation customers.

19.12(2) *General criteria.*

a. Natural gas utility companies may offer discounts to individual customers, to selected groups of customers, or to an entire class of customer. However, discounted rates must be offered to all directly competing customers in the same service territory. Customers are direct competitors if they make the same end product (or offer the same service) for the same general group of customers. Customers that only produce component parts of the same end product are not directly competing customers.

b. In deciding whether to offer a specific discount, the utility shall evaluate the individual customer's, group's, or class's situation and perform a cost-benefit analysis before offering the discount.

c. Any discount offered should be such as to significantly affect the customer's or customers' decision to stay on the system or to increase consumption.

d. The consequences of offering the discount should be beneficial to all customers and to the utility. Other customers should not be at risk of loss as a result of these discounts; in addition, the offering of discounts shall in no way lead to subsidization of the discounted rates by other customers in the same or different classes.

19.12(3) *Tariff requirements.* If a company elects to offer flexible rates, the utility shall file for review and approval tariff sheets specifying the general conditions for offering discounted rates. The tariff sheets shall include, at a minimum, the following criteria:

a. The cost-benefit analysis must demonstrate that offering the discount will be more beneficial than not offering the discount.

b. The ceiling for all discounted rates shall be the approved rate on file for the customer's rate class.

c. The floor for the discount sales rates shall be equal to the cost of gas. Therefore, the maximum discount allowed under the sales or transportation tariffs is equal to the nongas costs of serving the customer.

d. No discount shall be offered for a period longer than five years, unless the board determines upon good cause shown that a longer period is warranted.

e. Discounts should not be offered if they will encourage deterioration in the load characteristics of the customer receiving the discount.

f. Customer charges may be discounted.

19.12(4) *Reporting requirements.* Each natural gas utility electing to offer flexible rates shall file annual reports with the board within 30 days of the end of each 12 months. Reports shall include the following information:

a. Section 1 of the report concerns discounts initiated in the last 12 months. For all discounts initiated in the last 12 months, the report shall include:

(1) The identity of the new customers (by account number, if necessary);

(2) The value of the discount offered;

(3) The cost-benefit analysis results;

(4) The cost of alternate fuels available to the customer, if relevant;

(5) The volume of gas sold to or transported for the customer in the preceding 12 months; and

(6) A copy of all new or revised flexible rate contracts executed between the utility and its customers.

b. Section 2 of the report relates to overall program evaluation. For all discounts currently being offered, the report shall include:

(1) The identity of each customer (by account number, if necessary);

(2) The total volume of gas sold or transported in the last 12 months to each customer at discounted rates, by month;

(3) The volume of gas sold or transported to each customer in the same 12 months of the preceding year, by month;

(4) The dollar value of the discount in the last 12 months to each customer, by month;

(5) The dollar value of volumes sold or transported to each customer for each of the previous 12 months; and

(6) If customer charges are discounted, the dollar value of the discount shall be separately reported.

c. Section 3 of the report concerns discounts denied or discounts terminated. For all customers specifically evaluated and denied or having a discount terminated in the last 12 months, the report shall include:

(1) Customer identification (by account number, if necessary);

(2) The volume of gas sold or transported in the last 12 months to each customer, by month;

(3) The volume of gas sold or transported to each customer in the same 12 months of the preceding year, by month; and

(4) The dollar value of volumes sold or transported to each customer for each of the past 12 months.

d. No report is required if the utility had no customers receiving a discount during the relevant period and had no customers which were evaluated for the discount and rejected during the relevant period.

19.12(5) *Rate case treatment.* In a rate case, 50 percent of any identifiable increase in net revenues will be used to reduce rates for all customers; the remaining 50 percent of the identifiable increase in net revenues may be kept by the utility. If there is a decrease in revenues due to the discount, the utility's test year revenues will be adjusted to remove the effects of the discount by assuming that all sales or transportation services or customer charges were provided at full tariffed rate for the customer class. Determining the actual amount will be a factual determination to be made in the rate case.

199—19.13(476) Transportation service.

19.13(1) *Purpose.* This subrule requires gas distribution utility companies to transport natural gas owned by an end-user on a nondiscriminatory basis, subject to the capacity limitations of the specific system. System capacity is defined as the maximum flow of gas the relevant portion of the system is capable of handling. Capacity availability shall be determined using the total current firm gas flow, including both system and transportation gas.

19.13(2) *End-user rights.* The end-user purchasing transportation services from the utility shall have the following rights and be subject to the following conditions:

a. The end-user shall have the right to receive, pursuant to agreement, 100 percent of the gas delivered by it or on its behalf to the transporting utility (adjusted for a reasonable volume of lost, unaccounted-for, and company-used gas).

b. The volumes which the end-user is entitled to receive shall be subject to curtailment or interruption due to limitations in the system capacity of the transporting utility. Curtailment of the transportation volumes will take place according to the priority class, subdivision, or category which the end-user would have been assigned if it were purchasing gas from the transporting utility.

c. During periods of curtailment or interruption, the party is entitled to a credit equal to the difference between the volumes delivered to the utility and those received by the end-user, adjusted for lost, unaccounted-for, and company-used gas. The credit shall be available at any time, within the conditions of the agreement.

d. The end-user shall be responsible for all costs associated with any additional plant required for providing transportation services to the end-user.

19.13(3) *Transportation service charges.* Transportation service shall be offered to at least the following classes:

a. Interruptible service with system supply reserve.

b. Interruptible service without system supply reserve.

c. Firm service with system supply reserve.

d. Firm service without system supply reserve.

19.13(4) *Transportation service charges and rates.* All rates and charges for transportation shall be based on the cost of providing the service.

a. "System supply reserve" service shall entitle the end-user to return to the system service to the extent of the capacity purchased. The charge shall be at least equal to the administrative costs of monitoring the service, plus any other costs (including but not limited to gas demand costs which are directly assignable to the end-user).

b. End-users without system supply reserve service may only return to system service by paying an additional charge and are subject to the availability of adequate system capacity. An end-user wishing to receive transportation service without system supply reserve must pay the utility for the discounted value of any contract between the utility and the end-user remaining in effect at the time of beginning transportation service. The discounted values shall include all directly assignable and identifiable costs (including but not limited to gas costs).

c. The utility may require a reconnection charge when an end-user receiving transportation service without system supply reserve service requests to return to the system supply. The end-user shall return to the system and receive service under the appropriate classification as determined by the utility.

d. The end-user electing to receive transportation service shall pay reasonable rates for any use of the facilities, equipment, or services of the transporting utility.

e. Small volume transportation service. Rescinded IAB 4/28/04, effective 6/2/04.

f. Optional plan filing. Rescinded IAB 4/28/04, effective 6/2/04.

19.13(5) *Reporting requirements.* A natural gas utility shall file with the board two copies of each transportation contract entered into within 30 days of the date of execution. The utility may delete any information identifying the end-user and replace it with an identification number. The utility shall promptly supply the deleted information if requested by the board staff. The deleted information may be filed with a request for confidentiality, pursuant to 199 Iowa Administrative Code rule 1.9(22).

19.13(6) *Written notice of risks.* The utility must notify its large volume users as defined in 19.14(1) contracting for transportation service in writing that unless the customer buys system supply reserve service from the utility, the utility is not obligated to supply gas to the customer. The notice must also advise the large volume user of the nature of any identifiable penalties, any administrative or reconnection costs associated with purchasing available firm or interruptible gas, and how any available gas would be priced by the utility. The notice may be provided through a contract provision or separate written instrument. The large volume user must acknowledge in writing that it has been made aware of the risks and accepts the risks.

199—19.14(476) Certification of competitive natural gas providers and aggregators.

19.14(1) *Definitions.* The following words and terms, when used in these rules, shall have the meanings indicated below:

"Competitive natural gas provider" or *"CNGP"* means a person who takes title to natural gas and sells it for consumption by a retail end user in the state of Iowa, and it also means an aggregator as defined in Iowa Code section 476.86. CNGP includes an affiliate of an Iowa public utility. CNGP excludes the following:

1. A public utility which is subject to rate regulation under Iowa Code chapter 476.

2. A municipally owned utility which provides natural gas service within its incorporated area or within the municipal natural gas competitive service area, as defined in Iowa Code section 437A.3(21)*"a"*(1), in which the municipally owned utility is located.

"Competitive natural gas services" means natural gas sold at retail in this state excluding the sale of natural gas by a rate-regulated public utility or a municipally owned utility as provided in the definition of CNGP in 19.14(1).

"Large volume user" means any end user whose usage exceeds 25,000 therms in any month or 100,000 therms in any consecutive 12-month period.

"Small volume user" means any end user whose usage does not exceed 25,000 therms in any month and does not exceed 100,000 therms in any consecutive 12-month period.

19.14(2) *General requirement to obtain certificate.* A CNGP shall not provide competitive natural gas services to an Iowa retail end user without a certificate approved by the board pursuant to Iowa Code section 476.87. An exception to this requirement is a CNGP that has provided service to retail customers before April 25, 2001. A CNGP subject to this exception shall file for a certificate under the provisions of this rule on or before June 1, 2001, to continue providing service pending the approval of the certificate.

19.14(3) *Filing requirements and application process.* Applications shall be made in the format and contain all of the information required in 199—subrule 2.2(18). Applications must be filed with the executive secretary at Iowa Utilities Board, 1375 E. Court Avenue, Room 69, Des Moines, Iowa 50319-0069. An original and ten copies must be filed. An application fee of $125 must be included with the application to cover the administrative costs of accepting and processing a filing. In addition, each applicant will be billed an hourly rate for actual time spent by the board reviewing the application. Iowa Code section 476.87(3) requires the board to allocate the costs and expenses reasonably attributable to certification and dispute resolution to applicants and participants to the proceeding.

An applicant shall notify the board during the pendency of the certification request of any material change in the representations and commitments required by this subrule within 14 days of such change. Any new legal actions or formal complaints as identified in 199 IAC 2.2(18), numbered paragraph "4," are considered material changes in the request. Once certified, CNGPs shall notify the board of any material change in the representations and commitments required for certification within 14 days of such change.

19.14(4) *Deficiencies and board determination.* The board shall act on a certification application within 90 days unless it determines an additional 60 days is necessary. Applications will be considered complete and the 90-day period will commence when all required items are submitted. Applicants will be notified of deficiencies and given 30 days to complete applications. Applicants will be notified when their application is complete and the 90-day period commences.

19.14(5) *Conditions of certification.* CNGPs shall comply with the conditions set out in this subrule. Failure to comply with the conditions of certification may result in revocation of the certificate.

a. Unauthorized charges. A CNGP shall not charge or attempt to collect any charges from end users for any competitive natural gas services or equipment used in providing competitive natural gas services not contracted for or otherwise agreed to by the end user.

b. Notification of emergencies. Upon receipt of information from an end user of the existence of an emergency situation with respect to delivery service, a CNGP shall immediately contact the appropriate public utility whose facilities may be involved. The CNGP shall also provide the end user with the emergency telephone number of the public utility.

c. Reports to the board. Each CNGP shall file a report with the board on April 1 of each year for the 12-month period ending December 31 of the previous year. This information may be filed with a request for confidentiality, pursuant to 199—subrule 1.9(6). For each utility distribution system, the report shall contain the following information for its Iowa operations:

(1) The average number of small volume end users served per month.

(2) The average number of large volume end users served per month.

(3) The total volume of sales to small volume end users, by month.

(4) The total volume of sales to large volume end users, by month.

(5) The revenue collected from small volume end users for competitive natural gas services, excluding any revenue collected from end users on behalf of utilities.

(6) The revenue collected from large volume end users for competitive natural gas services, excluding any revenue collected from end users on behalf of utilities.

(7) The date the applicant began providing service in Iowa.

d. Rescinded IAB 4/28/04, effective 6/2/04.

19.14(6) *Additional conditions applicable to CNGPs providing service to small volume end users.* All CNGPs when providing service to small volume natural gas end users shall be subject to the following conditions in addition to those listed under subrule 19.14(5):

a. Customer deposits. Compliance with the following provisions shall apply to customers whose usage does not exceed 2500 therms in any month or 10,000 therms in any consecutive 12-month period.

Customer deposits – subrule 19.4(2)

Interest on customer deposits – subrule 19.4(3)

Customer deposit records – subrule 19.4(4)

Customer's receipt for a deposit – subrule 19.4(5)

Deposit refund – subrule 19.4(6)

Unclaimed deposits – subrule 19.4(7)

b. Bills to end users. A CNGP shall include on bills to end users all the information listed in this paragraph. The bill may be sent to the customer electronically at the customer's option.

(1) The period of time for which the billing is applicable.

(2) The amount owed for current service, including an itemization of all charges.

(3) Any past-due amount owed.

(4) The last date for timely payment.

(5) The amount of penalty for any late payment.

(6) The location for or method of remitting payment.

(7) A toll-free telephone number for the end user to call for information and to make complaints regarding the CNGP.

(8) A toll-free telephone number for the end user to contact the CNGP in the event of an emergency.

(9) A toll-free telephone number for the end user to notify the public utility of an emergency regarding delivery service.

(10) The tariffed transportation charges and supplier refunds, where a combined bill is provided to the customer.

c. Disclosure. Each prospective end user must receive in writing, prior to initiation of service, all terms and conditions of service and all rights and responsibilities of the end user associated with the offered service. The information required by this paragraph may be provided electronically, at the customer's option.

d. Notice of service termination. Notice must be provided to the end user and the public utility at least 12 calendar days prior to service termination. If the notice of service termination is rescinded, the CNGP must notify the public utility. CNGPs are prohibited from physically disconnecting the end user or threatening physical disconnection for any reason.

e. Transfer of accounts. CNGPs are prohibited from transferring the account of any end user to another supplier except with the consent of the end user. This provision does not preclude a CNGP from transferring all or a portion of its accounts pursuant to a sale or transfer of all or a substantial portion of a CNGP's business in Iowa, provided that the transfer satisfies all of the following conditions:

(1) The transferee will serve the affected end users through a certified CNGP;

(2) The transferee will honor the transferor's contracts with the affected end users;

(3) The transferor provides written notice of the transfer to each affected end user prior to the transfer;

(4) Any affected end user is given 30 days to change supplier without penalty; and

(5) The transferor provides notice to the public utility of the effective date of the transfer.

f. Bond requirement. The board may require the applicant to file a bond or other demonstration of its financial capability to satisfy claims and expenses that can reasonably be anticipated to occur as part of operations under its certificate, including the failure to honor contractual commitments. The adequacy of the bond or demonstration shall be determined by the board and reviewed by the board from time to time. In determining the adequacy of the bond or demonstration, the board shall consider the extent of the services to be offered, the size of the provider, and the size of the load to be served, with the objective of ensuring that the board's financial requirements do not create unreasonable barriers to market entry.

g. Replacement cost for supply failure. Each individual rate-regulated public utility shall file for the board's review tariffs establishing replacement cost for supply failure. Replacement cost revenue will be credited to the rate-regulated public utility's system purchased gas adjustment.
[Editorial change: IAC Supplement 12/29/10]

199—19.15(476) Customer contribution fund.

19.15(1) *Applicability and purpose.* This rule applies to each gas public utility, as defined in Iowa Code sections 476.1 and 476.1B. Each utility shall maintain a program plan to assist the utility's low-income customers with weatherization and to supplement assistance received under the federal low-income home energy assistance program for the payment of winter heating bills.

19.15(2) *Program plan.* Each utility shall have on file with the board a detailed description of its program plan. At a minimum, the plan shall include the following information:

a. A list of the members of the governing board, council, or committee established to determine the appropriate distribution of the funds collected. The list shall include the organization each member represents;

b. A sample of the customer notification with a description of the method and frequency of its distribution;

c. A sample of the authorization form provided to customers; and

d. The date of implementation.

Program plans for new customer contribution funds shall be rejected if not in compliance with this rule.

19.15(3) *Notification.* Each utility shall notify all customers of the fund at least twice a year. The method of notice which will ensure the most comprehensive notification to the utility's customers shall be employed. Upon commencement of service and at least once a year, the notice shall be mailed or personally delivered to all customers. The other required notice may be published in a local newspaper(s) of general circulation within the utility's service territory. A utility serving fewer than 6,000 customers may publish their semiannual notices locally in a free newspaper, utility newsletter or shopper's guide instead of a newspaper. At a minimum the notice shall include:

a. A description of the availability and the purpose of the fund;

b. A customer authorization form. This form shall include a monthly billing option and any other methods of contribution.

19.15(4) *Methods of contribution.* The utility shall provide for contributions as monthly pledges, as well as one-time or periodic contributions. Each utility may allow persons or organizations to contribute matching funds.

19.15(5) *Annual report.* On or before September 30 of each year, each utility shall file with the board a report of all the customer contribution fund activity for the previous fiscal year beginning July 1 and ending June 30. The report shall be in a form provided by the board and shall contain an accounting of the total revenues collected and all distributions of the fund. The utility shall report all utility expenses directly related to the customer contribution fund.

19.15(6) *Binding effect.* A pledge by a customer or other party shall not be construed to be a binding contract between the utility and the pledgor. The pledge amount shall not be subject to delayed payment charges by the utility.

199—19.16(476) Reserve margin.

19.16(1) *Applicability.* All rate-regulated gas utility companies may maintain a reserve of contract services in excess of their maximum daily system demand requirement and recover the cost of the reserve from their customers through the purchased gas adjustment.

19.16(2) *Definitions.*

a. Contract services. The amount of firm gas delivery capacity or delivery services contracted for use by a utility to satisfy its maximum daily system demand requirement, including the planned delivery capacity of the utility-owned liquefied natural gas facilities, but excluding the delivery capacity of propane storage facilities, shall be considered as contract services.

b. Maximum daily system demand requirements. The maximum daily gas demand requirement that the utility forecasts to occur on behalf of its system firm sales customers under peak (design day) weather conditions.

c. Design day. The maximum heating season forecast level of all firm sales customers' gas requirements during a 24-hour period beginning at 9 a.m. The design day forecast shall be the combined estimated gas requirements of all firm sales customers calculated by totaling the gas requirements of each customer classification or grouping. The estimated gas requirements for each customer classification or grouping shall be determined based upon an evaluation of historic usage levels of customers in each customer classification or grouping, adjusted for reasonably anticipated colder-than-normal weather conditions and any other clearly identifiable factors that may contribute to the demand for gas by firm customers. The design day calculation shall be submitted for approval by the board with the annual PGA filing required by subrule 19.10(2).

19.16(3) *Maximum daily system demand requirements of less than 25,000 Dth per day.* A reserve margin of 9 percent or less in excess of the maximum daily system demand requirements will be presumed reasonable.

19.16(4) *Maximum daily system demand requirements of more than 25,000 Dth per day.* A reserve margin of 5 percent or less in excess of the maximum daily system demand requirements will be presumed reasonable.

19.16(5) *Rebuttable presumption.* All contract services in excess of an amount needed to meet the maximum daily system demand requirements plus the reserve are presumed to be unjust and unreasonable unless a factual showing to the contrary is made during the periodic review of gas proceeding or in a proceeding specifically addressing the issue with an opportunity for an evidentiary hearing. All contract services less than an amount of the maximum daily system demand requirements plus the reserve are presumed to be just and reasonable unless a factual showing to the contrary can be made during the periodic review of gas proceeding or in a proceeding specifically addressing the issue with an opportunity for an evidentiary hearing.

19.16(6) *Allocation of cost of the reserve.* Fifty percent of the reserve cost shall be collected as a demand charge allocation to noncontractual firm customers. The remaining 50 percent shall be collected as a throughput charge on customers excluding transportation customers who have elected no system supply reserve.

199—19.17(476) Incident notification and reports.

19.17(1) *Notification.* A utility shall notify the board immediately, or as soon as practical, of any incident involving the release of gas, failure of equipment, or interruption of facility operations, which results in any of the following:

a. A death or personal injury necessitating in-patient hospitalization.

b. Estimated property damage of $15,000 or more to the property of the utility and to others, including the cost of gas lost.

c. Emergency shutdown of a liquefied natural gas (LNG) facility.

d. An interruption of service to 50 or more customers.

e. Any other incident considered significant by the utility.

19.17(2) *Information required.* The utility shall notify the board by telephone, as soon as practical, of any reportable incident by calling the board duty officer at (515)745-2332 or by E-mail at

iubdutyofficer@iub.iowa.gov. The caller shall leave a call-back number for a person who can provide the following information:

a. The name of the utility, the name and telephone number of the person making the report, and the name and telephone number of a contact person knowledgeable about the incident.

b. The location of the incident.

c. The time of the incident.

d. The number of deaths or personal injuries and the extent of those injuries, if any.

e. An initial estimate of damages.

f. The number of services interrupted.

g. A summary of the significant information available to the utility regarding the probable cause of the incident and extent of damages.

h. Any oral or written report required by the U.S. Department of Transportation, and the name of the person who made the oral report or prepared the written report.

19.17(3) *Written incident reports.* Within 30 days of the date of the incident, the utility shall file a written report with the board. The report shall include the information required for telephone notice in subrule 19.17(2), the probable cause as determined by the utility, the number and cause of any deaths or personal injuries requiring in-patient hospitalization, and a detailed description of property damage and the amount of monetary damages. If significant additional information becomes available at a later date, a supplemental report shall be filed. Copies of any written reports concerning an incident or safety-related condition filed with or submitted to the U.S. Department of Transportation or the National Transportation Safety Board shall also be provided to the board.

[Editorial change: IAC Supplement 12/29/10]

These rules are intended to implement 42 U.S.C.A. 8372, 10 CFR, 516.30, and Iowa Code sections 476.1, 476.2, 476.6, 476.8, 476.20, 476.54, 476.66, 476.86, 476.87 and 546.7.

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1 Effective date of 19.3(10)*"a," "b,"*(1), (2), (2)"1," (3) and (4) delayed 70 days by administrative rules review committee.

2 Effective date of 19.4(11), third unnumbered paragraph, delayed 70 days by administrative rules review committee.

3 See IAB, Utilities Division

4 Published in Notice portion of IAB 9/10/86; See IAB 10/22/86

5 Effective date of 19.4(3) delayed until the adjournment of the 1994 Session of the General Assembly pursuant to Iowa Code section 17A.8(9) by the Administrative Rules Review Committee at its meeting held September 15, 1993.

CHAPTER 20
SERVICE SUPPLIED BY ELECTRIC UTILITIES
[Prior to 10/8/86, Commerce Commission[250]]

199—20.1(476) General information.

20.1(1) *Authorization of rules.* Iowa Code chapter 476 provides that the Iowa utilities board shall establish all needful, just and reasonable rules, not inconsistent with law, to govern the exercise of its powers and duties, the practice and procedure before it, and to govern the form, content and filing of reports, documents and other papers necessary to carry out the provisions of this law.

Iowa Code chapter 478 provides that the Iowa utilities board shall have power to make and enforce rules relating to the location, construction, operation and maintenance of certain electrical transmission lines.

The application of the rules in this chapter to municipally owned utilities furnishing electricity is limited by Iowa Code section 476.1B, and the application of the rules in this chapter to electric utilities with fewer than 10,000 customers and to electric cooperative associations is limited by the provisions of Iowa Code section 476.1A.

20.1(2) *Application of rules.* The rules shall apply to any electric utility operating within the state of Iowa subject to Iowa Code chapter 476, and to the construction, operation and maintenance of electric transmission lines to the extent provided in Iowa Code chapter 478, and shall supersede all tariffs on file with the board which are in conflict with these rules.

These rules are intended to promote safe and adequate service to the public, to provide standards for uniform and reasonable practices by utilities, and to establish a basis for determining the reasonableness of such demands as may be made by the public upon the utilities.

A request to waive the application of any rule on a permanent or temporary basis may be made in accordance with 199—1.3(17A,474,476,78GA,HF2206).

The adoption of these rules shall in no way preclude the board from altering or amending them pursuant to statute or from making such modifications with respect to their application as may be found necessary to meet exceptional conditions.

These rules shall in no way relieve any utility from any of its duties under the laws of this state.

20.1(3) *Definitions.* The following words and terms when used in these rules, shall have the meaning indicated below:

"Acid Rain Program" means the sulfur dioxide and nitrogen oxides air pollution control program established pursuant to Title IV of the Act under 40 CFR Parts 72-78.

"Act" means the Clean Air Act, 42 U.S.C. Section 7401, et seq., as amended by Pub. L. 101-549, November 15, 1990.

"Affected unit" means a unit or source that is subject to any emission reduction requirement or limitation under the Acid Rain Program, the Clean Air Interstate Rule (CAIR) or the Clean Air Mercury Rule (CAMR), or a unit or source that opts in under 40 CFR Part 74.

"Allowance" means an authorization, allocated by the United States Environmental Protection Agency (EPA) under the Acid Rain Program, to emit sulfur dioxide (SO_2), any SO_2 and nitrogen oxide (NO_X) emissions subject to the Clean Air Interstate Rule (CAIR), or mercury (Hg) emissions subject to the Clean Air Mercury Rule (CAMR), during or after a specified calendar year.

"Allowance forward contract" is an agreement between a buyer and seller to transfer an allowance on a specified future date at a specified price.

"Allowance futures contract" is an agreement between a futures exchange clearinghouse and a buyer or seller to buy or sell an allowance on a specified future date at a specified price.

"Allowance option contract" is an agreement between a buyer and seller whereby the buyer has the option to transfer an allowance(s) at a specified date at a specified price. The seller of a call or put option will receive a premium for taking on the associated risk.

"Board" means the utilities board.

"Clean Air Interstate Rule" or *"CAIR"* means the requirements EPA published in the Federal Register (70 Fed. Reg. 25161) on May 12, 2005.

"Clean Air Mercury Rule" or *"CAMR"* means the requirements EPA published in the Federal Register (70 Fed. Reg. 28605) on May 18, 2005.

"Complaint" as used in these rules is a statement or question by anyone, whether a utility customer or not, alleging a wrong, grievance, injury, dissatisfaction, illegal action or procedure, dangerous condition or action, or utility obligation.

"Compliance plan" means the document submitted for an affected source to the EPA which specifies the methods by which each affected unit at the source will meet the applicable emissions limitation and emissions reduction requirements.

"Customer" means any person, firm, association, or corporation, any agency of the federal, state or local government, or legal entity responsible by law for payment for the electric service or heat from the electric utility.

"Delinquent" or *"delinquency"* means an account for which a service bill or service payment agreement has not been paid in full on or before the last day for timely payment.

"Distribution line" means any single or multiphase electric power line operating at nominal voltage in either of the following ranges: 2,000 to 26,000 volts between ungrounded conductors or 1,155 to 15,000 volts between grounded and ungrounded conductors, regardless of the functional service provided by the line.

"Economy energy" is energy bought or sold in a transaction wherein the supplier's incremental cost is less than the buyer's decremental cost, and the differential in cost is shared in an equitable manner by the supplier and buyer.

"Electric plant" includes all real estate, fixtures and property owned, controlled, operated or managed in connection with or to facilitate production, generation, transmission, or distribution, in providing electric service or heat by an electric utility.

"Electric service" is furnishing to the public for compensation any electricity, heat, light, power, or energy.

"Emission for emission trade" is an exchange of one type of emission for another type of emission. For example, the exchange of SO_2 emission allowances for NO_X emission allowances.

"Energy" means electric energy measured in kilowatt hours.

"Firm power" is power and associated energy intended to be available at all times during the period covered by the commitment.

"Gains and losses from allowance sales" are calculated as the difference between the sale price of allowances sold during the month and the weighted average unit cost of inventoried allowances.

"Meter" means, unless otherwise qualified, a device that measures and registers the integral of an electrical quantity with respect to time.

"Meter shop" is a shop where meters are inspected, repaired and tested, and may be at a fixed location or may be mobile.

"Operating reserve" is a reserve generating capacity required to ensure reliability of generation resources.

"Operational control energy" is energy supplied by a selling utility to a buying utility for the improvement of electric system operation.

"Outage energy" is energy purchased during emergency or scheduled maintenance outages of generation or transmission facilities, or both.

"Participation power" means power and associated energy or energy which is purchased or sold from a specific unit or units on the basis that its availability is subject to prorate or other specified reduction if the units are not operated at full capacity.

"Peaking power" is power and associated energy intended to be available at all times during the commitment and which is anticipated to have low load factor use.

"Power" means electric power measured in kilowatts.

"Price hedging" means using futures contracts or options to guard against unfavorable price changes.

"Rate-regulated utility" means any utility, as defined in 20.1(3),which is subject to board rate regulation under Iowa Code chapter 476.

"Secondary line" means any single or multiphase electric power line operating at nominal voltage less than either 2,000 volts between ungrounded conductors or 1,155 volts between grounded and ungrounded conductors, regardless of the functional service provided by the line.

"Service limitation" means the establishment of a limit on the amount of power that may be consumed by a residential customer through the installation of a service limiter on the customer's meter.

"Service limiter" or *"service limitation device"* means a device that limits a residential customer's power consumption to 3,600 watts (or some higher level of usage approved by the board) and that resets itself automatically, or can be reset manually by the customer, and may also be reset remotely by the utility at all times.

"Speculation" means using futures contracts or options to profit from expectations of future price changes.

"Tariff" means the entire body of rates, tolls, rentals, charges, classifications, rules, procedures, policies, etc., adopted and filed with the board by an electric utility in fulfilling its role of furnishing service.

"Timely payment" is a payment on a customer's account made on or before the date shown on a current bill for service, or on a form which records an agreement between the customer and a utility for a series of partial payments to settle a delinquent account, as the date which determines application of a late payment charge to the current bill or future collection efforts.

"Transmission line" means any single or multiphase electric power line operating at nominal voltages at or in excess of either 69,000 volts between ungrounded conductors or 40,000 volts between grounded and ungrounded conductors, regardless of the functional service provided by the line.

"Utility" means any person, partnership, business association or corporation, domestic or foreign, owning or operating any facilities for providing electric service or heat to the public for compensation.

"Vintage trade" is an exchange of one vintage of allowances for another vintage of allowances with the difference in value between vintages being cash or additional allowances.

"Weighted average unit cost of inventoried allowances" equals the dollars in inventory at the end of the month divided by the total allowances available for use at the end of the month.

"Wheeling service" is the service provided by a utility in consenting to the use of its transmission facilities by another party for the purpose of scheduling delivery of power or energy, or both.

20.1(4) *Abbreviations.* The following abbreviations may be used where appropriate:

ANSI—American National Standards Institute, 1430 Broadway, New York, New York 10018.

DOE—Department of Energy, Washington, D.C. 20426.

EPA—United States Environmental Protection Agency.

FCC—Federal Communications Commission, 1919 M Street, Washington, D.C. 20554.

FERC—Federal Energy Regulatory Commission, Washington, D.C. 20426.

NARUC—National Association of Regulatory Utility Commissioners, P.O. Box 684, Washington, D.C. 20044.

NBS—National Bureau of Standards, Washington, D.C. 20234.

NFPA—National Fire Protection Association, 470 Atlantic Ave., Boston, Massachusetts 02210.

[**ARC 7976B**, IAB 7/29/09, effective 9/2/09]

199—20.2(476) Records, reports, and tariffs.

20.2(1) *Location and retention of records.* Unless otherwise specified by this chapter, all records required by these rules shall be kept and preserved in accordance with the applicable provisions of 199—Chapter 18.

20.2(2) *Tariffs to be filed with the board.* The schedules of rates and rules of rate-regulated electric utilities shall be filed with the board and shall be classified, designated, arranged and submitted so as to conform to the requirements of this chapter. Provisions of the schedules shall be definite and so stated as to minimize ambiguity or the possibility of misinterpretation. The form, identification and content of tariffs shall be in accordance with these rules.

Utilities which are not subject to the rate regulation provided for by Iowa Code chapter 476 shall not be required to file schedules of rates, rules, or contracts primarily concerned with a rate schedule with the

board and shall not be subject to the provisions related to rate regulations, but nothing contained in these rules shall be deemed to relieve any utility of the requirement of furnishing any of these same schedules or contracts which are needed by the board in the performance of the board's duties upon request to do so by the board.

20.2(3) *Form and identification.* All tariffs shall conform to the following rules:

a. The tariff shall be printed, typewritten or otherwise reproduced on 8½- × 11- inch sheets of durable white paper so as to result in a clear and permanent record. The sheets of the tariff should be ruled or spaced to set off a border on the left side suitable for binding. In the case of utilities subject to regulation by any federal agency the format of sheets of tariff as filed with the board may be the same format as is required by the federal agency provided that the rules of the board as to title page; identity of superseding, replacing or revision sheets; identity of amending sheets: identity of the filing utility, issuing official, date of issue, effective date; and the words "Tariff with board" shall apply in the modification of the federal agency format for the purposes of filing with this board.

b. The title page of every tariff and supplement shall show:

(1) The first page shall be the title page which shall show:

(Name of Public Utility)
Electric Tariff
Filed with
Iowa Utilities Board

(Date)

(This requirement does not apply to tariffs or amendments filed with the board prior to July 1, 1981.)

(2) When a tariff is to be superseded or replaced in its entirety, the replacing tariff shall show on the upper right corner of its title page that it supersedes a tariff on file and the number being superseded or replaced, for example:

TARIFF NO. _____
SUPERSEDES TARIFF NO. _____

(This requirement does not apply to tariffs or amendments filed with the board prior to July 1, 1981.)

(3) When a new part of a tariff eliminates an existing part of a tariff it shall so state and clearly indicate the part eliminated.

(4) Any tariff modifications as defined above shall be marked in the right-hand margin of the replacing tariff sheet with symbols as here described to indicate the place, nature and extent of the change in text.

—Symbols—

(C)—Changed regulation
(D)—Discontinued rate or regulation
(I)—Increase in rate or new treatment resulting in increased rate
(N)—New rate, treatment or regulation
(R)—Reduction in rate or new treatment resulting in reduced rate
(T)—Change in text only

c. All sheets except the title page shall have, in addition to the above-stated requirements, the following information:

(1) Name of utility under which shall be set forth the words "Filed with board." If the utility is not a corporation, and a trade name is used, the name of the individual or partners must precede the trade name.

(2) Issuing official and issue date.

(3) Effective date (to be left blank by rate-regulated utilities).

d. All sheets except the title page shall have the following form:

(Company Name)	(Part identification)
Electric Tariff	(This sheet identification)
Filed with board	(Canceled sheet identification, if any)
	(Content or tariff)
Issued: (Date)	Effective:
Issued by: (Name, title)	(Proposed Effective Date:)

The issued date is the date the tariff or the amended sheet content was adopted by the utility.

The effective date will be left blank by rate-regulated utilities and shall be determined by the board. The utility may propose an effective date.

20.2(4) *Content of tariffs.*

a. A table of contents containing a list of rate schedules and other sections in the order in which they appear showing the sheet numbers of the first page of each rate schedule or other section. In the event the utility filing the tariff elects to segregate a section such as general rules from the section containing the rate schedules or other sections, it may at its option prepare a separate table of contents for each such segregated section.

b. A preliminary statement containing a brief general explanation of the utility's operations.

c. All rates for service with indication for each rate of the type and voltage of service and the class of customers to which each rate applies. There shall also be shown any limitations on loads and type of equipment which may be connected, the net prices per unit of service and the number of units per billing period to which the net prices apply, the period of billing, the minimum bill, any effect of transformer capacity upon minimum bill or upon the number of kWh in any step of the rate, method of measuring demands, method of calculating or estimating loads in cases where transformer capacity has a bearing upon minimum bill or size of rate steps, level payment plan, and any special terms or conditions applicable. The period during which the net amount may be paid before the account becomes delinquent shall be specified. In any case where net and gross amounts are billed, the difference between net and gross is a late payment charge and shall be so specified.

d. The voltage and type of service, (direct current or single or polyphase alternating current) supplied in each municipality, but without reference required to any particular part thereof.

e. Forms of standard contracts required of customers for the various types of service available.

f. If service to other utilities or municipalities is furnished at a standard filed rate, either a copy of each signed contract or a copy of the standard uniform contract form together with a summary of the provisions of each signed contract. The summary shall show the principal provisions of the contract and shall include the name and address of the customer, the points where energy is delivered, rate, term, minimum, load conditions, voltage of delivery and any special provisions such as rentals. Standard contracts for such sales as that of energy for resale, street lighting, municipal athletic field lighting, and for water utilities may be filed in summary form as above outlined.

g. Copies of special contracts for the purchase, sale, or interchange of electrical energy. All tariffs must provide that, notwithstanding any other provision of this tariff or contract with reference thereto, all rates and charges contained in this tariff or contract with reference thereto may be modified at any time by a subsequent filing made pursuant to the provisions of Iowa Code chapter 476.

h. A list of all communities in which service is furnished.

i. The list of service areas and the rates shall be filed in a form to facilitate ready determination of the rates available in each municipality and in unincorporated communities that have service. If the utility has various rural rates, the areas where the same are available shall be indicated.

j. Definitions of classes of customers.

k. Extension rules for extending service to new customers indicating what portion of the extension or cost thereof will be furnished by the utility; and if the rule is based on cost, the items of cost included.

l. Type of construction which the utility requires the customer to provide if in excess of the Iowa electric safety code or the requirements of the municipality having jurisdiction, whichever may be the most stringent in any particular.

m. Specification of such portion of service as the utility furnishes, owns, and maintains, such as service drop, service entrance cable or conductors, conduits, service entrance equipment, meter and socket. Indication of the portions of interior wiring such as range or water heater connection, furnished in whole or in part by the utility, and statement indicating final ownership and responsibility for maintaining equipment furnished by utility.

n. Statement of the type of special construction commonly requested by customers which the utility allows to be connected, and terms upon which such construction will be permitted, with due provision for the avoidance of unjust discrimination as between customers who request special construction and those who do not. This applies, for example, to a case where a customer desires underground service in overhead territory.

o. Rules with which prospective customers must comply as a condition of receiving service, and the terms of contracts required.

p. Rules governing the establishment and maintenance of credit by customers for payment of service bills.

q. Rules governing the procedure followed in disconnecting and reconnecting service.

r. Notice required from a customer for having service discontinued.

s. Rules covering temporary, emergency, auxiliary and stand-by service.

t. Rules covering the type of equipment which may or may not be connected, including rules such as those requiring demand-limiting devices or power-factor corrective equipment.

u. General statement of the method used in making adjustments for wastage of electricity when accidental grounds exist without the knowledge of the customer.

v. Statements of utility rules on meter reading, bill issuance, customer payment, notice of delinquency, and service discontinuance for nonpayment of bill.

w. Rules for extending service in accordance with 20.3(13).

x. If a sliding scale or automatic adjustment is applicable to regulated rates and charges of billed customers, the manner and method of such adjustment calculation shall be covered through a detailed explanation.

y. Rules on how a customer or prospective customer should file a complaint with the utility, and how the complaint will be processed.

z. Rules on how a customer, disconnected customer or potential customer for residential service may negotiate for a payment agreement on amount due, determination of even payment amounts, and time allowed for payments.

20.2(5) *Annual, periodic and other reports to be filed with the board.*

a. System map verification. The utility shall file annually a verification that it has a currently correct set of utility system maps in accordance with general requirement 20.3(11) and a statement as to the location of the utility's offices where such maps are accessible and available for examination by the board or its agents. The verification and map location information shall also be reported to the board upon other occasions when significant changes occur in either the maps or location of the maps.

b. Accident reports. Rescinded IAB 12/11/91, effective 1/15/92. See 199—25.5(476,478).

c. Rescinded IAB 11/13/02, effective 12/18/02.

d. Electric service record. Each utility shall compile a monthly record of electric service showing the production, acquisition and disposition of electric energy, the number of customer terminal voltage investigations made, the number of customer meters tested and such other information as may be required by the board. The monthly "Electric Service" record shall be compiled not later than 30 days after the end of the month covered and such record shall, upon and after compilation, be kept available for inspection by the board or its staff at the utility's principal office within the state of Iowa. A summary of the 12 monthly "Electric Service" records for each calendar year shall be attached to and submitted with the utility's annual report to the board.

e. The utility shall keep the board informed currently by written notice as to the location at which the utility keeps the various classes of records required by these rules.

f. A copy of the utility's current rules, if any, published or furnished by the utility for the use of engineers, architects, electrical contractors, etc., covering meter and service installations shall be filed with the board.

g. A copy of each type of customer bill form in current use shall be filed with the board.

h. A copy of the adjustment calculation shall be provided the board prior to each billing cycle on the forms adopted by the board.

i. Rescinded IAB 1/9/91, effective 2/13/91.

j. Residential customer statistics. Each rate-regulated electric utility shall file with the board on or before the fifteenth day of each month one copy of the following residential customer statistics for the preceding month:

(1) Number of accounts;
(2) Number of accounts certified as eligible for energy assistance since the preceding October 1;
(3) Number of accounts past due;
(4) Number of accounts eligible for energy assistance and past due;
(5) Total revenue owed on accounts past due;
(6) Total revenue owed on accounts eligible for energy assistance and past due;
(7) Number of disconnection notices issued;
(8) Number of disconnection notices issued on accounts eligible for energy assistance;
(9) Number of disconnections for nonpayment;
(10) Number of reconnections;
(11) Number of accounts determined uncollectible; and
(12) Number of accounts eligible for energy assistance and determined uncollectible.

k. List of persons authorized to receive board inquiries. Each utility shall file with the board in the annual report required in 199—subrule 23.1(2) a list of names, titles, addresses, and telephone numbers of persons authorized to receive, act upon, and respond to communications from the board in connection with: (1) general management duties; (2) customer relations (complaints); (3) engineering operations; (4) meter tests and repairs; (5) franchises for electric lines; (6) certificates for electric generating plants. Each utility shall file with the board a telephone contact number where the board can obtain current information 24 hours a day about outages and interruptions of service from a knowledgeable person. The contact information required by this paragraph shall be kept current as changes or corrections are made.

This rule is intended to implement Iowa Code section 476.2.

199—20.3(476) General service requirements.

20.3(1) *Disposition of electricity.* The meter and associated instrument transformers shall be owned by the utility. The wiring between the instrument transformers and the meter shall be owned or controlled by the utility. The utility shall place a visible seal on all meters in customer use, such that the seal must be broken to gain entry.

a. All electricity sold by a utility shall be on the basis of meter measurement except:

(1) Where the consumption of electricity may be readily computed without metering; or
(2) For temporary service installations.

b. The amount of all electricity delivered to multioccupancy premises within a single building, where units are separately rented or owned, shall be measured on the basis of individual meter measurement for each unit, except in the following instances:

(1) Where electricity is used in centralized heating, cooling, water-heating, or ventilation systems;
(2) Where a facility is designated for elderly or handicapped persons;
(3) Where submetering or resale of service was permitted prior to 1966; or
(4) Where individual metering is impractical. "Impractical" means: (1) where conditions or structural barriers exist in the multioccupancy building that would make individual meters unsafe or physically impossible to install; (2) where the cost of providing individual metering exceeds the long-term benefits of individual metering; or (3) where the benefits of individual metering (reduced and controlled energy consumption) are more effectively accomplished through a master meter arrangement.

If a multioccupancy building is master-metered, the end-user occupants may be charged for electricity as an unidentified portion of the rent, condominium fee, or similar payment, or, if some other method of allocating the cost of the electric service is used, the total charge for electric service shall not exceed the total electric bill charged by the utility for the same period.

c. Master metering to multiple buildings is prohibited, except for multiple buildings owned by the same person or entity. Multioccupancy premises within a multiple building complex may be master-metered pursuant to this paragraph only if the requirements of paragraph 20.3(1)*"b"* have been met.

d. For purposes of this subrule, a "master meter" means a single meter used in determining the amount of electricity provided to a multioccupancy building or multiple buildings.

e. This rule shall not be construed to prohibit any utility from requiring more extensive individual metering than otherwise required by this rule if pursuant to tariffs filed with and approved by the board.

f. All electricity consumed by the utility shall be on the basis of meter measurement except where consumption may be readily computed without metering, or where metering is impractical.

20.3(2) *Condition of meter.* Rescinded IAB 11/12/03, effective 12/17/03.

20.3(3) *Meter reading records.* The meter reading records shall show:

a. Customer's name, address, and rate schedule or identification of rate schedule.

b. Identification of the meter or meters either by permanently marked utility number or by manufacturer's name, type number and serial number.

c. Meter readings.

d. If the reading has been estimated.

e. Any applicable multiplier or constant.

20.3(4) *Meter charts.* All charts taken from recording meters shall be marked with the initial and final date and hour of the record, the meter identification, customer's name and location and the chart multiplier.

20.3(5) *Meter register.* If it is necessary to apply a multiplier to the meter readings, the multiplier must be marked on the face of the meter register or stenciled in weather resistant paint upon the front cover of the meter. Customers shall have continuous visual access to meter registers as a means of verifying the accuracy of bills presented to them and for implementing such energy conservation initiatives as they desire, except in the individual locations where the utility has experienced vandalism to windows in the protective enclosures. Where remote meter reading is used, whether outdoor on premises or off premises automated, the customer shall also have readable meter registers at the meter.

Where magnetic tape or other delayed processing means is used the utility may comply by having readable kWh registers only, visually accessible.

In instances in which the utility has determined that readable access, to locations existing July 1, 1981, will create a safety hazard, the utility is exempted from the access provisions above.

In instances when a building owner has determined that unrestricted access to tenant metering installation would create a vandalism or safety hazard the utility is exempted from the access provision above.

Continuing efforts should be made to eliminate or minimize the number of restricted locations. The utility should assist affected customers in obtaining meter register information.

20.3(6) *Meter reading and billing interval.* Readings of all meters used for determining charges and billings to customers shall be scheduled at least monthly and for the beginning and termination of service. Bills to larger customers may, for good cause, be rendered weekly or daily for a period not to exceed one month. Intervals other than monthly shall not be applied to smaller customers, or to larger customers after the initial month provided above, without a waiver from the board. A waiver request must include sufficient information to comply with 199—1.3(17A,474,476,78GA,HF2206). If the board denies a waiver, or if a waiver is not sought with respect to a high demand customer after the initial month, that customer's meter shall be read monthly for the next 12 months. The group of larger customers to which shorter billing intervals may be applied shall be specified in the utility's tariff sheets, but shall not include residential customers.

An effort shall be made to obtain readings of the meters on corresponding days of each meter-reading period. When the meter reading date causes a given billing period to deviate by more than 10 percent (counting only business days) from the normal meter reading period, such bills shall be prorated on a daily basis.

The utility may permit the customer to supply the meter readings by telephone or on a form supplied by the utility. The utility may arrange for customer meter reading forms to be delivered to the utility by United States mail, electronically, or by hand delivery. The utility may arrange for the meter to be read by electronic means. Unless the utility has a plan to test check meter readings, a utility representative shall physically read the meter at least once each 12 months.

In the event that the utility leaves a meter reading form with the customer when access to meters cannot be gained and the form is not returned in time for the billing operation, an estimated bill may be rendered.

If an actual meter reading cannot be obtained, the utility may render an estimated bill without reading the meter or supplying a meter reading form to the customer. Only in unusual cases or when approval is obtained from the customer shall more than three consecutive estimated bills be rendered.

20.3(7) *Demand meter registration.* When a demand meter is used for billing, the meter installation should be designed so that the highest expected annual demand reading to be used for billing will appear in the upper half of the meter's range.

20.3(8) *Service areas.* Service areas are defined by the boundaries on service area maps, available for viewing during regular business hours at the board's offices, and available for purchase at the cost of reproduction. These service area maps are adopted as part of this rule and are incorporated in this rule by this reference.

20.3(9) *Petition for modification of service area and answers.* An exclusive service area is subject to modification through a contested case proceeding which may be commenced by filing a petition for modification of service area with the board. The board may commence a service area modification proceeding on its own motion.

Any electric utility or municipal corporation may file a petition for modification of service area which shall contain a legal description of the service area desired, a designation of the utilities involved in each boundary section, and a justification for the proposed service area modification. The justification shall include a detailed statement of why the proposed modification is in the public interest. A map showing the affected areas which complies with subrule 20.3(11)*"a"* shall be attached to the petition as an exhibit. The petition shall be delivered by the United States Postal Service or personal service and shall be considered as filed with the agency on the date of the postmark or the date of personal service.

Copies of the petition shall be served on all utilities involved and the consumer advocate. Those utilities and the consumer advocate shall be parties of record to the proceeding.

All parties shall file an answer which complies with 199—subrule 7.5(1).

20.3(10) *Certificate of authority.* Any electric utility or municipal corporation requesting a service territory modification pursuant to subrule 20.3(9) which would result in service to a customer by a utility other than the utility currently serving the customer must also petition the board for a certificate of authority under Iowa Code section 476.23. The electric utility or municipal corporation shall pay the party currently serving the customer a reasonable price for the facilities serving the customer.

20.3(11) *Maps.*

a. Each utility shall maintain a current map or set of maps showing the physical location of electric lines, stations, and electric transmission facilities for its service areas. The maps shall include the exact location of the following:

(1) Generating stations with capacity designation.

(2) Purchased power supply points with maximum contracted capacity designation.

(3) Purchased power metering points if located at other than power delivery points.

(4) Transmission lines with size and type of conductor designation and operating voltage designation.

(5) Transmission-to-transmission voltage transformation substations with transformer voltage and capacity designation.

(6) Transmission-to-distribution voltage transformation substations with transformer voltage and capacity designation.

(7) Distribution lines with size and type of conductor designation, phase designation and voltage designation.

(8) All points at which transmission, distribution or secondary lines of the utility cross Iowa state boundaries.

(9) All current information required in Iowa Code section 476.24(1).

(10) All county boundaries and county names.

(11) Natural and artificial lakes which cover more than 50 acres and all rivers.

(12) Any additional information required by the board.

b. All maps shall be available for examination at the utility's designated offices during the utility's regular office hours. The maps shall be drawn with clean, uniform lines to a scale of one inch per mile. A large scale shall be used where it is necessary to clarify areas where there is a heavy concentration of facilities. All cartographic details shall be clean cut, and the background shall contain little or no coloration or shading.

20.3(12) Rescinded, IAB 6/29/88, effective 8/3/88.

20.3(13) *Plant additions, electrical line extensions and service lines.*

a. Definitions. The following definitions shall apply to the terms used in this subrule:

"Advance for construction," as used in this subrule, means cash payments or equivalent surety made to the utility by an applicant for an extensive plant addition or an electrical line extension, portions of which may be refunded depending on the attachment of any subsequent service line made to the extensive plant addition or electrical line extension. Cash payments or equivalent surety shall include a grossed-up amount for the income tax effect of such revenue. The amount of tax shall be reduced by the present value of the tax benefits to be obtained by depreciating the property in determining tax liability.

"Agreed-upon attachment period," as used in this subrule, means a period of not less than 30 days nor more than one year mutually agreed upon by the utility and the applicant within which the customer will attach. If no time period is mutually agreed upon, the agreed-upon attachment period shall be deemed to be 30 days.

"Contribution in aid of construction," as used in this subrule, means a nonrefundable cash payment grossed-up for the income tax effect of such revenue covering the costs of an electrical line extension or service line that are in excess of costs paid by the utility. The amount of tax shall be reduced by the present value of the tax benefits to be obtained by depreciating the property in determining the tax liability.

"Electrical line extensions" means distribution line extensions and secondary line extensions as defined in subrule 20.1(3), except for service lines as defined in this subrule.

"Equivalent overhead transformer cost," as used in this subrule, is that transformer capitalized cost, or fraction thereof, that would be required for similarly situated customers served by a pole-mounted or platform-mounted transformer(s). For each overhead service, it shall be the capitalized cost of the transformer(s) divided by the number of customers served by that transformer(s). For each underground service, it shall be the capitalized cost of an overhead transformer(s) with the same voltage and volt-ampere rating divided by the number of customers served by that transformer(s).

"Estimated annual revenues," as used in this subrule, shall be calculated based upon the following factors, including, but not limited to: The size of the facility to be used by the customer, the size and type of equipment to be used by the customer, the average annual amount of service required by the equipment, and the average number of hours per day and days per year the equipment will be in use.

"Estimated base revenues," as used in this subrule, shall be calculated by subtracting the fuel expense costs as described in the uniform system of accounts as adopted by the board and energy efficiency charges from the estimated annual revenues.

"Estimated construction costs," as used in this subrule, shall be calculated using average current costs in accordance with good engineering practices and upon the following factors: amount of service required or desired by the customer requesting the electrical line extension or service line; size, location, and characteristics of the electrical line extension or service line, including appurtenances, except

equivalent overhead transformer cost; and whether the ground is frozen or whether other adverse conditions exist. In no event shall estimated construction costs include costs associated with facilities built for the convenience of the utility. The customer shall be charged actual permit fees in addition to estimated construction costs. Permit fees are to be paid regardless of whether the customer is required to pay an advance for construction or a nonrefundable contribution in aid of construction, and the cost of any permit fee is not refundable.

"Plant addition," as used in this subrule, means any additional plant required to be constructed to provide service to a customer other than an electrical line extension or service line.

"Point of attachment" is that point of first physical attachment of the utilities' service drop (overhead) or service lateral (underground) conductors to the customer's service entrance conductors. For overhead services it shall be the point of tap or splice to the service entrance conductors. For underground services it shall be the point of tap or splice to the service entrance conductors in a terminal box or meter or other enclosure with adequate space inside or outside the building wall. If there is no terminal box, meter, or other enclosure with adequate space, it shall be the point of entrance into the building.

"Service line," as used in this subrule, means any secondary line extension, as defined in subrule 20.1(3), on private property serving a single customer or point of attachment of electric service.

"Similarly situated customer," as used in this subrule, means a customer whose annual consumption or service requirements, as defined by estimated annual revenue, are approximately the same as the annual consumption or service requirements of other customers.

"Utility," as used in this subrule, means a rate-regulated utility.

b. Plant additions. The utility shall provide all electric plant at its cost and expense without requiring an advance for construction from customers or developers except in those unusual circumstances where extensive plant additions are required before the customer can be served. A written contract between the utility and the customer which requires an advance for construction by the customer to make plant additions shall be available for board inspection.

c. Electrical line extensions. Where the customer will attach to the electrical line extension within the agreed-upon attachment period after completion of the electrical line extension, the following shall apply:

(1) The utility shall finance and make the electrical line extension for a customer without requiring an advance for construction if the estimated construction costs to provide an electrical line extension are less than or equal to three times estimated base revenue calculated on the basis of similarly situated customers. The utility may use a feasibility model, rather than three times estimated base revenue, to determine what, if any, advance for construction is required by the customer. The utility shall file a summary explaining the inputs into the feasibility model and a description of the model as part of the utility's tariff. Whether or not the construction of the electrical line extension would otherwise require a payment from the customer, the utility shall charge the customer for actual permit fees, and the permit fees are not refundable.

(2) If the estimated construction cost to provide an electrical line extension is greater than three times estimated base revenue calculated on the basis of similarly situated customers, the applicant for the electrical line extension shall contract with the utility and make, no more than 30 days prior to commencement of construction, an advance for construction equal to the estimated construction cost less three times estimated base revenue to be produced by the customer. The utility may use a feasibility model to determine whether an advance for construction is required. The utility shall file a summary explaining the inputs into the feasibility model and a description of the model as part of the utility's tariff. A written contract between the utility and the customer shall be available for board inspection upon request. Whether or not the construction of the electrical line extension would otherwise require a payment from the customer, the utility shall charge the customer for actual permit fees, and the permit fees are not refundable.

(3) Where the customer will not attach within the agreed-upon attachment period after completion of the electrical line extension, the applicant for the electrical line extension shall contract with the utility and make, no more than 30 days prior to the commencement of construction, an advance for construction

equal to the estimated construction cost. The utility may use a feasibility model to determine the amount of the advance for construction. The utility shall file a summary explaining the inputs into the feasibility model and a description of the model as part of the utility's tariff. A written contract between the utility and the customer shall be available for board inspection upon request. Whether or not the construction of the electrical line extension would otherwise require a payment from the customer, the utility shall charge the customer for actual permit fees, and the permit fees are not refundable.

(4) Advances for construction may be paid by cash or equivalent surety and shall be refundable for ten years. The customer has the option of providing an advance for construction by cash or equivalent surety unless the utility determines that the customer has failed to comply with the conditions of a surety in the past.

(5) Refunds. When the customer is required to make an advance for construction, the utility shall refund to the depositor for a period of ten years from the date of the original advance a pro-rata share for each service line attached to the electrical line extension. The pro-rata refund shall be computed in the following manner:

1. If the combined total of three times estimated base revenue, or the amount allowed by the feasibility model, for the electrical line extension and each service line attached to the electrical line extension exceeds the total estimated constriction cost to provide the electrical line extension, the entire amount of the advance for construction provided shall be refunded.

2. If the combined total of three times estimated base revenue, or the amount allowed by the feasibility model, for the electrical line extension and each service line attached to the electrical line extension is less than the total estimated construction cost to provide the electrical line extension, the amount to be refunded shall equal three times estimated base revenue, or the amount allowed by the feasibility model, when a service line is attached to the electrical line extension.

3. In no event shall the total amount to be refunded exceed the amount of the advance for construction. Any amounts subject to refund shall be paid by the utility without interest. At the expiration of the above-described ten-year period, the advance for construction record shall be closed and the remaining balance shall be credited to the respective plant account.

(6) The utility shall keep a record of each work order under which the electrical line extension was installed, to include the estimated revenues, the estimated construction costs, the amount of any payment received, and any refunds paid.

d. Service lines.

(1) The utility shall finance and construct either an overhead or underground service line without requiring a nonrefundable contribution in aid of construction or any payment by the applicant where the length of the overhead service line to the first point of attachment is up to 50 feet on private property or where the cost of the underground service line to the meter or service disconnect is less than or equal to the estimated cost of constructing an equivalent overhead service line of up to 50 feet.

(2) Where the length of the overhead service line exceeds 50 feet on private property, the applicant shall be required to provide a nonrefundable contribution in aid of construction for that portion of the service line on private property, exclusive of the point of attachment, within 30 days after completion. The nonrefundable contribution in aid of construction for that portion of the service line shall be computed as follows:

(Estimated Construction Costs) ×

$$\frac{\text{(Total Length in Excess of 50 Feet)}}{\text{(Total Length of Service Line)}}$$

(3) Where the cost of the underground service line exceeds the estimated cost of constructing an equivalent overhead service line of up to 50 feet, the applicant shall be required to provide a nonrefundable contribution in aid of construction within 30 days after completion equal to the difference between the estimated cost of constructing the underground service line and the estimated cost of constructing an equivalent overhead service line of up to 50 feet.

(4) A utility may adopt a tariff or rule that allows the utility to finance and construct a service line of more than 50 feet without requiring a nonrefundable contribution in aid of construction from the customer if the tariff or rule applies equally to all customers or members.

(5) Whether or not the construction of the service line would otherwise require a payment from the customer, the utility shall charge the customer for actual permit fees.

e. Extensions not required. Utilities shall not be required to make electrical line extensions or install service lines as described in this subrule, unless the electrical line extension or service line shall be of a permanent nature.

f. Different payment arrangement. This subrule shall not be construed as prohibiting any utility from making a contract with a customer using a different payment arrangement, if the contract provides a more favorable payment arrangement to the customer, so long as no discrimination is practiced among customers.

This rule is intended to implement Iowa Code section 476.8.

[**ARC 7584B**, IAB 2/25/09, effective 4/1/09]

199—20.4(476) Customer relations.

20.4(1) *Customer information.* Each utility shall:

a. Maintain up-to-date maps, plans, or records of its entire transmission and distribution systems, together with such other information as may be necessary to enable the utility to advise prospective customers, and others entitled to the information, as to the facilities available for serving prospective customers in its service area.

b. Assist the customer or prospective customer in selecting the most economical rate schedule available for the customer's proposed type of service.

c. Notify customers affected by a change in rates or schedule classification in the manner provided in the rules of practice and procedure before the board. [199—7.4(476)IAC]

d. Post a notice in a conspicuous place in each office of the utility where applications for service are received, informing the public that copies of the rate schedules and rules relating to the service of the utility, as filed with the board, are available for public inspection. If the utility has provided access to its rate schedules and rules for service on its Web site, the notice should include the Web site address.

e. Upon request, inform its customers as to the method of reading meters.

f. State, on the bill form, that tariff and rate schedule information is available upon request at the utility's local business office.

g. Upon request, transmit a statement of either the customer's actual consumption, or degree day adjusted consumption, at the company's option, of electricity for each billing during the prior 12 months.

h. Furnish such additional information as the customer may reasonably request.

20.4(2) *Customer contact employee qualifications.* Each utility shall promptly and courteously resolve inquiries for information or complaints. Employees who receive customer telephone calls and office visits shall be qualified and trained in screening and resolving complaints, to avoid a preliminary recitation of the entire complaint to employees without ability and authority to act. The employee shall provide identification to the customer that will enable the customer to reach that employee again if needed.

Each utility shall notify its customers, by bill insert or notice on the bill form, of the address and telephone number where a utility representative qualified to assist in resolving the complaint can be reached. The bill insert or notice shall also include the following statement: "If (utility name) does not resolve your complaint, you may request assistance from the Iowa Utilities Board by calling (515)725-7321, or toll-free 1-877-565-4450, or by writing to 1375 E. Court Avenue, Room 69, Des Moines, Iowa 50319-0069, or by E-mail to customer@iub.iowa.gov."

The bill insert or notice for municipal utilities shall include the following statement: "If your complaint is related to service disconnection, safety, or renewable energy, and (utility name) does not resolve your complaint, you may request assistance from the Iowa Utilities Board by calling (515)725-7321, or toll-free 1-877-565-4450, by writing to 1375 E. Court Avenue, Room 69, Des Moines, Iowa 50319-0069, or by E-mail to customer@iub.iowa.gov."

The bill insert or notice for non-rate-regulated rural electric cooperatives shall include the following statement: "If your complaint is related to the (utility name) service rather than its rates, and (utility name) does not resolve your complaint, you may request assistance from the Iowa Utilities Board by calling (515)725-7321, or toll-free 1-877-565-4450, by writing to 1375 E. Court Avenue, Room 69, Des Moines, Iowa 50319-0069, or by E-mail to customer@iub.iowa.gov."

The bill insert or notice on the bill shall be provided monthly by utilities serving more than 50,000 Iowa retail customers and no less than annually by all other electric utilities. Any utility which does not use the standard statement described in this subrule shall file its proposed statement in its tariff for approval. A utility that bills by postcard may place an advertisement in a local newspaper of general circulation or a customer newsletter instead of a mailing. The advertisement must be of a type size that is easily legible and conspicuous and must contain the information set forth above.

20.4(3) *Customer deposits.*

a. Each utility may require from any customer or prospective customer a deposit intended to guarantee partial payment of bills for service. Each utility shall allow a person other than the customer to pay the customer's deposit. In lieu of a cash deposit, the utility may accept the written guarantee of a surety or other responsible party as surety for an account. Upon termination of a guarantee contract, or whenever the utility deems the contract insufficient as to amount or surety, a cash deposit or a new or additional guarantee may be required for good cause upon reasonable written notice.

b. A new or additional deposit may be required from a customer when a deposit has been refunded or is found to be inadequate. Written notice shall be mailed advising the customer of any new or additional deposit requirement. The customer shall have no less than 12 days from the date of mailing to comply. The new or additional deposit shall be payable at any of the utility's business offices or local authorized agents. An appropriate receipt shall be provided. No written notice is required to be given of a deposit required as a prerequisite for commencing initial service.

c. No deposit shall be required as a condition for service other than determined by application of either credit rating or deposit calculation criteria, or both, of the filed tariff.

d. The total deposit for any residential or commercial customer for a place which has previously received service shall not be greater than the highest billing of service for one month for the place in the previous 12-month period. The deposit for any residential or commercial customer for a place which has not previously received service, or for an industrial customer, shall be the customer's projected one-month usage for the place to be served as determined by the utility, or as may be reasonably required by the utility in cases involving service for short periods or special occasions.

20.4(4) *Interest on customer deposits.* Interest shall be paid by the rate-regulated utility to each customer required to make a deposit. On or after April 21, 1994, rate-regulated utilities shall compute interest on customer deposits at 7.5 percent per annum, compounded annually. Interest for prior periods shall be computed at the rate specified by the rule in effect for the period in question. Interest shall be paid for the period beginning with the date of deposit to the date of refund or to the date that the deposit is applied to the customer's account, or to the date the customer's bill becomes permanently delinquent. The date of refund is that date on which the refund or the notice of deposit refund is forwarded to the customer's last-known address. The date a customer's bill becomes permanently delinquent, relative to an account treated as an uncollectible account, is the most recent date the account became delinquent.

20.4(5) *Customer deposit records.* Each utility shall keep records to show:

a. The name and address of each depositor.

b. The amount and date of the deposit.

c. Each transaction concerning the deposit.

20.4(6) *Customer's receipt for a deposit.* Each utility shall issue a receipt of deposit to each customer from whom a deposit is received, and shall provide means whereby a depositor may establish claim if the receipt is lost.

20.4(7) *Deposit refund.* A deposit shall be refunded after 12 consecutive months of prompt payment (which may be 11 timely payments and 1 automatic forgiveness of late payment). For refund purposes the account shall be reviewed for prompt payment after 12 months of service following the making of the deposit and for each 12-month interval terminating on the anniversary of the deposit. However,

deposits received from customers subject to the exemption provided by 20.4(3)*"b,"* including surety deposits, may be retained by the utility until final billing. Upon termination of service, the deposit plus accumulated interest, less any unpaid utility bill of the customer, shall be reimbursed to the person who made the deposit.

20.4(8) *Unclaimed deposits.* The utility shall make a reasonable effort to return each unclaimed deposit and accrued interest after the termination of the services for which the deposit was made. The utility shall maintain a record of deposit information for at least two years or until such time as the deposit, together with accrued interest, escheats to the state pursuant to Iowa Code section 556.4, at which time the record and deposit, together with accrued interest less any lawful deductions, shall be sent to the state treasurer pursuant to Iowa Code section 556.11.

20.4(9) *Customer bill forms.* Each customer shall be informed as promptly as possible following the reading of the customer's meter, on bill form or otherwise, of the following:

a. The reading of the meter at the beginning and at the end of the period for which the bill is rendered.

b. The dates on which the meter was read, at the beginning and end of the billing period.

c. The number and kind of units metered.

d. The applicable rate schedule, or identification of the applicable rate schedule.

e. The account balance brought forward and amount of each net charge for rate-schedule-priced utility service, sales tax, other taxes, late payment charge, and total amount currently due. In the case of prepayment meters, the amount of money collected shall be shown.

f. The last date for timely payment shall be clearly shown and shall be not less than 20 days after the bill is rendered.

g. A distinct marking to identify an estimated bill.

h. A distinct marking to identify a minimum bill.

i. Any conversions from meter reading units to billing units, or any calculations to determine billing units from recording or other devices, or any other factors, such as sliding scale or automatic adjustment and amount of sales tax adjustments used in determining the bill.

j. Customer billing information alternate. A utility serving less than 5000 electric customers may provide the information in 20.4(9) on bill form or otherwise. If the utility elects not to provide the information of 20.4(9), it shall advise the customer, on bill form or by bill insert, that such information can be obtained by contacting the utility's local office.

20.4(10) Rescinded, effective 7/1/81.

20.4(11) *Payment agreements.*

a. Availability of a first payment agreement. When a residential customer cannot pay in full a delinquent bill for utility service or has an outstanding debt to the utility for residential utility service and is not in default of a payment agreement with the utility, a utility shall offer the customer an opportunity to enter into a reasonable payment agreement.

b. Reasonableness. Whether a payment agreement is reasonable will be determined by considering the current household income, ability to pay, payment history including prior defaults on similar agreements, the size of the bill, the amount of time and the reasons why the bill has been outstanding, and any special circumstances creating extreme hardships within the household. The utility may require the person to confirm financial difficulty with an acknowledgment from the department of human services or another agency.

c. Terms of payment agreements.

(1) *First payment agreement.* The utility shall offer customers who have received a disconnection notice or have been disconnected 120 days or less and who are not in default of a payment agreement the option of spreading payments evenly over at least 12 months by paying specific amounts at scheduled times. The utility shall offer customers who have been disconnected more than 120 days and who are not in default of a payment agreement the option of spreading payments evenly over at least 6 months by paying specific amounts at scheduled times.

1. The agreement shall also include provision for payment of the current account. The agreement negotiations and periodic payment terms shall comply with tariff provisions which are consistent with

these rules. The utility may also require the customer to enter into a level payment plan to pay the current bill.

2. When the customer makes the agreement in person, a signed copy of the agreement shall be provided to the customer.

3. The utility may offer the customer the option of making the agreement over the telephone or through electronic transmission. When the customer makes the agreement over the telephone or through electronic transmission, the utility shall render to the customer a written document reflecting the terms and conditions of the agreement within three days of the date the parties entered into the oral agreement or electronic agreement. The document will be considered rendered to the customer when addressed to the customer's last-known address and deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the document shall be considered rendered to the customer when delivered to the last-known address of the person responsible for payment for the service. The document shall state that unless the customer notifies the utility within ten days from the date the document is rendered, it will be deemed that the customer accepts the terms as reflected in the written document. The document stating the terms and agreements shall include the address and a toll-free or collect telephone number where a qualified representative can be reached. By making the first payment, the customer confirms acceptance of the terms of the oral agreement or electronic agreement.

4. Each customer entering into a first payment agreement shall be granted at least one late payment that is made four days or less beyond the due date for payment and the first payment agreement shall remain in effect.

(2) *Second payment agreement.* The utility shall offer a second payment agreement to a customer who is in default of a first payment agreement if the customer has made at least two consecutive full payments under the first payment agreement. The second payment agreement shall be for the same term as or longer than the term of the first payment agreement. The customer shall be required to pay for current service in addition to the monthly payments under the second payment agreement and may be required to make the first payment up-front as a condition of entering into the second payment agreement. The utility may also require the customer to enter into a level payment plan to pay the current bill. The utility may offer additional payment agreements to the customer.

d. Refusal by utility. A customer may offer the utility a proposed payment agreement. If the utility and the customer do not reach an agreement, the utility may refuse the offer orally, but the utility must render a written refusal to the customer, stating the reason for the refusal, within three days of the oral notification. The written refusal shall be considered rendered to the customer when addressed to the customer's last-known address and deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the written refusal shall be considered rendered to the customer when handed to the customer or when delivered to the last-known address of the person responsible for the payment for the service.

A customer may ask the board for assistance in working out a reasonable payment agreement. The request for assistance must be made to the board within ten days after the rendering of the written refusal. During the review of this request, the utility shall not disconnect the service.

20.4(12) *Bill payment terms.* The bill shall be considered rendered to the customer when deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the bill shall be considered rendered when delivered to the last-known address of the party responsible for payment. There shall not be less than 20 days between the rendering of a bill and the date by which the account becomes delinquent. Bills for customers on more frequent billing intervals under subrule 20.3(6) may not be considered delinquent less than 5 days from the date of rendering. However, a late payment charge may not be assessed if payment is received within 20 days of the date the bill is rendered.

a. The date of delinquency for all residential customers or other customers whose consumption is less than 3,000 kWh per month, shall be changeable for cause in writing; such as, but not limited to, 15 days from approximate date each month upon which income is received by the person responsible for payment. In no case, however, shall the utility be required to delay the date of delinquency more than 30 days beyond the date of preparation of the previous bill.

b. In any case where net and gross amounts are billed to customers, the difference between net and gross is a late payment charge and is valid only when part of a delinquent bill payment. A utility's late payment charge shall not exceed 1.5 percent per month of the past due amount. No collection fee may be levied in addition to this late payment charge. This rule does not prohibit cost-justified charges for disconnection and reconnection of service.

c. If the customer makes partial payment in a timely manner, and does not designate the service or product for which payment is made, the payment shall be credited pro rata between the bill for utility services and related taxes.

d. Each account shall be granted not less than one complete forgiveness of a late payment charge each calendar year. The utility's rules shall be definitive that on one monthly bill in each period of eligibility, the utility will accept the net amount of such bill as full payment for such month after expiration of the net payment period. The rules shall state how the customer is notified that the eligibility has been used. Complete forgiveness prohibits any effect upon the credit rating of the customer or collection of late payment charge.

e. Level payment plan. Utilities shall offer a level payment plan to all residential customers or other customers whose consumption is less than 3,000 kWh per month. A level payment plan should be designed to limit the volatility of a customer's bill and maintain reasonable account balances. The level payment plan shall include at least the following:

(1) Be offered to each eligible customer when the customer initially requests service.

(2) Allow for entry into the level payment plan anytime during the calendar year.

(3) Provide that a customer may request termination of the plan at any time. If the customer's account is in arrears at the time of termination, the balance shall be due and payable at the time of termination. If there is a credit balance, the customer shall be allowed the option of obtaining a refund or applying the credit to future charges. A utility is not required to offer a new level payment plan to a customer for six months after the customer has terminated from a level payment plan.

(4) Use a computation method that produces a reasonable monthly level payment amount, which may take into account forward-looking factors such as fuel price and weather forecasts, and that complies with requirements in 20.4(12)*"e"*(4). The computation method used by the utility shall be described in the utility's tariff and shall be subject to board approval. The utility shall give notice to customers when it changes the type of computation method in the level payment plan.

The amount to be paid at each billing interval by a customer on a level payment plan shall be computed at the time of entry into the plan and shall be recomputed at least annually. The level payment amount may be recomputed monthly, quarterly, when requested by the customer, or whenever price, consumption, or a combination of factors results in a new estimate differing by 10 percent or more from that in use.

When the level payment amount is recomputed, the level payment plan account balance shall be divided by 12, and the resulting amount shall be added to the estimated monthly level payment amount. Except when a utility has a level payment plan that recomputes the level payment amount monthly, the customer shall be given the option of applying any credit to payments of subsequent months' level payment amounts due or of obtaining a refund of any credit in excess of $25.

Except when a utility has a level payment plan that recomputes the level payment amount monthly, the customer shall be notified of the recomputed payment amount not less than one full billing period prior to the date of delinquency for the recomputed payment. The notice may accompany the bill prior to the bill that is affected by the recomputed payment amount.

(5) Irrespective of the account balance, a delinquency in payment shall be subject to the same collection and disconnection procedures as other accounts, with the late payment charge applied to the level payment amount. If the account balance is a credit, the level payment plan may be terminated by the utility after 30 days of delinquency.

20.4(13) *Customer records.* The utility shall retain records as may be necessary to effectuate compliance with 20.4(14) and 20.6(6), but not less than three years. Records for customer shall show where applicable:

a. kWh meter reading

b. kWh consumption
c. kW meter reading
d. kW measured demand
e. kW billing demand
f. Total amount of bill.

20.4(14) *Adjustment of bills.*

a. Meter error. Whenever a meter creeps or whenever a metering installation is found upon any test to have an average error of more than 2.0 percent for watthour metering; or a demand metering error of more than 1.5 percent in addition to the errors allowed under accuracy of demand metering; an adjustment of bills for service for the period of inaccuracy shall be made in the case of overregistration and may be made in the case of underregistration. The amount of the adjustment shall be calculated on the basis that the metering equipment should be 100 percent accurate with respect to the testing equipment used to make the test. For watthour metering installations the average accuracy shall be the arithmetic average of the percent registration at 10 percent of rated test current and at 100 percent of rated test current giving the 100 percent of rated test current registration a weight of four and the 10 percent of rated test current registration a weight of one.

b. Determination of adjustment. Recalculation of bills shall be on the basis of actual monthly consumption except that if service has been measured by self-contained single-phase meters or three-wire network meters and involves no billing other than for kilowatt-hours, the recalculation of bills may be based on the average monthly consumption determined from the most recent 36 months, consumption data.

When the average error cannot be determined by test because of failure of part or all of the metering equipment, it shall be permissible to use the registration of check metering installations, if any, or to estimate the quantity of energy consumed based on available data. The customer must be advised of the failure and of the basis for the estimate of quantity billed. The periods of error shall be used as defined in immediately following subparagraphs (1) and (2).

(1) Overregistration. If the date when overregistration began can be determined, such date shall be the starting point for determination of the amount of the adjustment. If the date when overregistration began cannot be determined, it shall be assumed that the error has existed for the shortest time period calculated as one-half the time since the meter was installed, or one-half the time elapsed since the last meter test unless otherwise ordered by the board.

The overregistration due to creep shall be calculated by timing the rate of creeping and assuming that the creeping affected the registration of the meter for 25 percent of the time since the more recent of either metering installation or last previous test.

(2) Underregistration. If the date when underregistration began can be determined, it shall be the starting point for determination of the amount of the adjustment except that billing adjustment shall be limited to the preceding six months. If the date when underregistration began cannot be determined, it shall be assumed that the error has existed for one-half of the time elapsed since the more recent of either meter installation or the last meter test, except that billing adjustment shall be limited to the preceding six months unless otherwise ordered by the board.

The underregistration due to creep shall be calculated by timing the rate of creeping and assuming that this creeping affected the registration for 25 percent of the time since the more recent of either metering installation or last previous test, except that billing adjustment shall be limited to the preceding six months.

c. Refunds. If the recalculated bills indicate that $5 or more is due an existing customer or $10 or more is due a person no longer a customer of the utility, the tariff shall provide refunding of the full amount of the calculated difference between the amount paid and the recalculated amount. Refunds shall be made to the two most recent customers who received service through the metering installation found to be in error. In the case of a previous customer who is no longer a customer of the utility, a notice of the amount subject to refund shall be mailed to such previous customer at the last-known address, and the utility shall, upon demand made within three months thereafter, refund the same.

Refunds shall be completed within six months following the date of the metering installation test.

d. Back billing. A utility may not back bill due to underregistration unless a minimum back bill amount is specified in its tariff. The minimum amount specified for back billing shall not be less than, but may be greater than, $5 for an existing customer or $10 for a former customer. All recalculations resulting in an amount due equal or greater than the tariff specified minimum shall result in issuance of a back bill.

Back billings shall be rendered no later than six months following the date of the metering installation test.

e. Overcharges. When a customer has been overcharged as a result of incorrect reading of the meter, incorrect application of the rate schedule, incorrect connection of the metering installation or other similar reasons, the amount of the overcharge shall be adjusted, refunded or credited to the customer. The time period for which the utility is required to adjust, refund, or credit the customer's bill shall not exceed five years unless otherwise ordered by the board.

f. Undercharges. When a customer has been undercharged as a result of incorrect reading of the meter, incorrect application of the rate schedule, incorrect connection of the meter or other similar reasons, the amount of the undercharge may be billed to the customer. The period for which the utility may adjust for the undercharge shall not exceed five years unless otherwise ordered by the board. The maximum back bill shall not exceed the dollar amount equivalent to the tariffed rate for like charges (e.g., usage-based, fixed or service charges) in the 12 months preceding discovery of the error unless otherwise ordered by the board.

g. Credits and explanations. Credits due a customer because of meter inaccuracies, errors in billing, or misapplication of rates shall be separately identified.

20.4(15) *Refusal or disconnection of service.* A utility shall refuse service or disconnect service to a customer, as defined in subrule 20.1(3), in accordance with tariffs that are consistent with these rules.

a. The utility shall give written notice of pending disconnection except as specified in paragraph 20.4(15)*"b."* The notice shall set forth the reason for the notice and the final date by which the account is to be settled or specific action taken. The notice shall be considered rendered to the customer when addressed to the customer's last-known address and deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the notice shall be considered rendered when delivered to the last-known address of the person responsible for payment for the service. The date for disconnection of service shall be not less than 12 days after the notice is rendered. The date for disconnection of service for customers on shorter billing intervals under subrule 20.3(6) shall not be less than 24 hours after the notice is posted at the service premises.

One written notice, including all reasons for the notice, shall be given where more than one cause exists for disconnection of service. In determining the final date by which the account is to be settled or other specific action taken, the days of notice for the causes shall be concurrent.

b. Service may be disconnected without notice:

(1) In the event of a condition on the customer's premises determined by the utility to be hazardous.

(2) In the event of customer use of equipment in a manner which adversely affects the utility's equipment or the utility's service to others.

(3) In the event of tampering with the equipment furnished and owned by the utility. For the purposes of this subrule, a broken or absent meter seal alone shall not constitute tampering.

(4) In the event of unauthorized use.

c. Service may be disconnected or refused after proper notice:

(1) For violation of or noncompliance with the utility's rules on file with the board.

(2) For failure of the customer to furnish the service equipment, permits, certificates, or rights-of-way which are specified to be furnished, in the utility's rules filed with the board, as conditions of obtaining service, or for the withdrawal of that same equipment, or for the termination of those same permissions or rights, or for the failure of the customer to fulfill the contractual obligations imposed as conditions of obtaining service by any contract filed with and subject to the regulatory authority of the board.

(3) For failure of the customer to permit the utility reasonable access to the utility's equipment.

d. Service may be refused or disconnected after proper notice for nonpayment of a bill or deposit, except as restricted by subrules 20.4(16) and 20.4(17), provided that the utility has complied with the following provisions when applicable:

(1) Given the customer a reasonable opportunity to dispute the reason for the disconnection or refusal.

(2) Given the customer, and any other person or agency designated by the customer, written notice that the customer has at least 12 days in which to make settlement of the account to avoid disconnection and a written summary of the rights and responsibilities available. Customers billed more frequently than monthly pursuant to subrule 20.3(6) shall be given posted written notice that they have 24 hours to make settlement of the account to avoid disconnection and a written summary of the rights and responsibilities. All written notices shall include a toll-free or collect telephone number where a utility representative qualified to provide additional information about the disconnection can be reached. Each utility representative must provide the representative's name and have immediate access to current, detailed information concerning the customer's account and previous contacts with the utility.

(3) The summary of the rights and responsibilities must be approved by the board. Any utility providing electric service and defined as a public utility in Iowa Code section 476.1 which does not use the standard form set forth below for customers billed monthly shall submit to the board an original and six copies of its proposed form for approval. A utility billing a combination customer for both gas and electric service may modify the standard form to replace each use of the word "electric" with the words "gas and electric" in all instances.

CUSTOMER RIGHTS AND RESPONSIBILITIES TO AVOID SHUTOFF OF ELECTRIC SERVICE FOR NONPAYMENT

1. What can I do if I receive a notice from the utility that says my service will be shut off because I have a past due bill?

a. Pay the bill in full; or

b. Enter into a reasonable payment plan with the utility (see #2 below); or

c. Apply for and become eligible for low-income energy assistance (see #3 below); or

d. Give the utility a written statement from a doctor or public health official stating that shutting off your electric service would pose an especial health danger for a person living at the residence (see #4 below); or

e. Tell the utility if you think part of the amount shown on the bill is wrong. However, you must still pay the part of the bill you agree you owe the utility (see #5 below).

2. How do I go about making a reasonable payment plan? (Residential customers only)

a. Contact the utility as soon as you know you cannot pay the amount you owe. If you cannot pay all the money you owe at one time, the utility may offer you a payment plan that spreads payments evenly over at least 12 months. The plan may be longer depending on your financial situation.

b. If you have not made the payments you promised in a previous payment plan with the utility and still owe money, you may qualify for a second payment agreement under certain conditions.

c. If you do not make the payments you promise, the utility may shut off your utility service on one day's notice unless all the money you owe the utility is paid or you enter into another payment agreement.

3. How do I apply for low-income energy assistance? (Residential customers only)

a. Contact the local community action agency in your area (see attached list); or

b. Contact the Division of Community Action Agencies at the Iowa Department of Human Rights, Lucas State Office Building, Des Moines, Iowa 50319; telephone (515)281-0859. To prevent disconnection, you must contact the utility prior to disconnection of your service.

c. To avoid disconnection, you must apply for energy assistance before your service is shut off. Notify your utility that you may be eligible and have applied for energy assistance. Once your service has been disconnected, it will not be reconnected based on approval for energy assistance.

d. Being certified eligible for energy assistance will prevent your service from being disconnected from November 1 through April 1.

4. What if someone living at the residence has a serious health condition? (Residential customers only)

Contact the utility if you believe this is the case. Contact your doctor or a public health official and ask the doctor or health official to contact the utility and state that shutting off your utility service would pose an especial health danger for a person living at your residence. The doctor or public health official must provide a written statement to the utility office within 5 days of when your doctor or public health official notifies the utility of the health condition; otherwise, your utility service may be shut off. If the utility receives this written statement, your service will not be shut off for 30 days. This 30-day delay is to allow you time to arrange payment of your utility bill or find other living arrangements. After 30 days, your service may be shut off if payment arrangements have not been made.

5. What should I do if I believe my bill is not correct?

You may dispute your utility bill. You must tell the utility that you dispute the bill. You must pay the part of the bill you think is correct. If you do this, the utility will not shut off your service for 45 days from the date the bill was mailed while you and the utility work out the dispute over the part of the bill you think is incorrect. You may ask the Iowa Utilities Board for assistance in resolving the dispute. (See #9 below.)

6. When can the utility shut off my utility service because I have not paid my bill?

a. Your utility can shut off service between the hours of 6 a.m. and 2 p.m., Monday through Friday.

b. The utility will not shut off your service on nights, weekends, or holidays for nonpayment of a bill.

c. The utility will not shut off your service if you enter into a reasonable payment plan to pay the overdue amount (see #2 above).

d. The utility will not shut off your service if the temperature is forecasted to be 20 degrees Fahrenheit or colder during the following 24-hour period, including the day your service is scheduled to be shut off.

e. If you have qualified for low-income energy assistance, the utility cannot shut off your service from November 1 through April 1. However, you will still owe the utility for the service used during this time.

f. The utility will not shut off your service if you have notified the utility that you dispute a portion of your bill and you pay the part of the bill that you agree is correct.

g. If one of the heads of household is a service member deployed for military service, utility service cannot be shut off during the deployment or within 90 days after the end of deployment. In order for this exception to disconnection to apply, the utility must be informed of the deployment prior to disconnection. However, you will still owe the utility for service used during this time.

7. How will I be told the utility is going to shut off my service?

a. You must be given a written notice at least 12 days before the utility service can be shut off for nonpayment. This notice will include the reason for shutting off your service.

b. If you have not made payments required by an agreed-upon payment plan, your service may be disconnected with only one day's notice.

c. The utility must also try to reach you by telephone or in person before it shuts off your service. From November 1 through April 1, if the utility cannot reach you by telephone or in person, the utility will put a written notice on the door of your residence to tell you that your utility service will be shut off.

8. If service is shut off, when will it be turned back on?

a. The utility will turn your service back on if you pay the whole amount you owe or agree to a reasonable payment plan (see #2 above).

b. If you make your payment during regular business hours, or by 7 p.m. for utilities permitting such payment or other arrangements after regular business hours, the utility must make a reasonable effort to turn your service back on that day. If service cannot reasonably be turned on that same day, the utility must do it by 11 a.m. the next day.

c. The utility may charge you a fee to turn your service back on. Those fees may be higher in the evening or on weekends, so you may ask that your service be turned on during normal utility business hours.

9. Is there any other help available besides my utility?

If the utility has not been able to help you with your problem, you may contact the Iowa Utilities Board toll-free at 1-877-565-4450. You may also write the Iowa Utilities Board at 1375 E.

Court Avenue, Room 69, Des Moines, Iowa 50319-0069, or by E-mail at customer@iub.iowa.gov. Low-income customers may also be eligible for free legal assistance from Iowa Legal Aid, and may contact Legal Aid at 1-800-532-1275.

(4) If the utility has adopted a service limitation policy pursuant to subrule 20.4(23), the following paragraph shall be appended to the end of the standard form for the summary of rights and responsibilities, as set forth in subparagraph 20.4(15)*"d"*(3):

Service limitation: We have adopted a limitation of service policy for customers who otherwise could be disconnected. Contact our business office for more information or to learn if you qualify.

(5) When disconnecting service to a residence, made a diligent attempt to contact, by telephone or in person, the customer responsible for payment for service to the residence to inform the customer of the pending disconnection and the customer's rights and responsibilities. During the period from November 1 through April 1, if the attempt at customer contact fails, the premises shall be posted at least one day prior to disconnection with a notice informing the customer of the pending disconnection and rights and responsibilities available to avoid disconnection.

If an attempt at personal or telephone contact of a customer occupying a rental unit has been unsuccessful, the landlord of the rental unit, if known, shall be contacted to determine if the customer is still in occupancy and, if so, the customer's present location. The landlord shall also be informed of the date when service may be disconnected.

If the disconnection will affect occupants of residential units leased from the customer, the premises of any building known by the utility to contain residential units affected by disconnection must be posted, at least two days prior to disconnection, with a notice informing any occupants of the date when service will be disconnected and the reasons for the disconnection.

(6) Disputed bill. If the customer has received notice of disconnection and has a dispute concerning a bill for electric utility service, the utility may require the customer to pay a sum of money equal to the amount of the undisputed portion of the bill pending settlement and thereby avoid disconnection of service. A utility shall delay disconnection for nonpayment of the disputed bill for up to 45 days after the rendering of the bill if the customer pays the undisputed amount. The 45 days shall be extended by up to 60 days if requested of the utility by the board in the event the customer files a written complaint with the board in compliance with 199—Chapter 6.

(7) Reconnection. Disconnection of a residential customer may take place only between the hours of 6 a.m. and 2 p.m. on a weekday and not on weekends or holidays. If a disconnected customer makes payment or other arrangements during normal business hours, or by 7 p.m. for utilities permitting such payment or other arrangements after normal business hours, all reasonable efforts shall be made to reconnect the customer that day. If a disconnected customer makes payment or other arrangements after 7 p.m., all reasonable efforts shall be made to reconnect the customer not later than 11 a.m. the next day.

(8) Severe cold weather. A disconnection may not take place where electricity is used as the only source of space heating or to control or operate the only space heating equipment at the residence on any day when the National Weather Service forecast for the following 24 hours covering the area in which the residence is located includes a forecast that the temperature will be 20 degrees Fahrenheit or colder. In any case where the utility has posted a disconnect notice in compliance with subparagraph 20.4(15)*"d"*(5) but is precluded from disconnecting service because of a National Weather Service forecast, the utility may immediately proceed with appropriate disconnection procedures, without further notice, when the temperature in the area where the residence is located rises above 20 degrees Fahrenheit and is forecasted to be above 20 degrees Fahrenheit for at least 24 hours, unless the customer has paid in full the past due amount or is entitled to postponement of disconnection under some other provision of paragraph 20.4(15)*"d."*

(9) Health of a resident. Disconnection of a residential customer shall be postponed if the disconnection of service would present an especial danger to the health of any permanent resident of the premises. An especial danger to health is indicated if a person appears to be seriously impaired and may, because of mental or physical problems, be unable to manage the person's own resources, to carry out activities of daily living or to be protected from neglect or hazardous situations without assistance from others. Indicators of an especial danger to health include but are not limited to: age, infirmity, or

mental incapacitation; serious illness; physical disability, including blindness and limited mobility; and any other factual circumstances which indicate a severe or hazardous health situation.

The utility may require written verification of the especial danger to health by a physician or a public health official, including the name of the person endangered; a statement that the person is a resident of the premises in question; the name, business address, and telephone number of the certifying party; the nature of the health danger; and approximately how long the danger will continue. Initial verification by the verifying party may be by telephone if written verification is forwarded to the utility within five days.

Verification shall postpone disconnection for 30 days. In the event service is terminated within 14 days prior to verification of illness by or for a qualifying resident, service shall be restored to that residence if a proper verification is thereafter made in accordance with the foregoing provisions. If the customer does not enter into a reasonable payment agreement for the retirement of the unpaid balance of the account within the first 30 days and does not keep the current account paid during the period that the unpaid balance is to be retired, the customer is subject to disconnection pursuant to paragraph 20.4(15)*"f."*

(10) Winter energy assistance (November 1 through April 1). If the utility is informed that the customer's household may qualify for winter energy assistance or weatherization funds, there shall be no disconnection of service for 30 days from the date the utility is notified to allow the customer time to obtain assistance. Disconnection shall not take place from November 1 through April 1 for a resident who is a head of household and who has been certified to the public utility by the community action agency as eligible for either the low-income home energy assistance program or weatherization assistance program.

(11) Deployment. If the utility is informed that one of the heads of household as defined in Iowa Code section 476.20 is a service member deployed for military service, as defined in Iowa Code section 29A.90, disconnection cannot take place at the residence during the deployment or prior to 90 days after the end of the deployment.

e. Abnormal electric consumption. A customer who is subject to disconnection for nonpayment of bill, and who has electric consumption which appears to the customer to be abnormally high, may request the utility to provide assistance in identifying the factors contributing to this usage pattern and to suggest remedial measures. The utility shall provide assistance by discussing patterns of electric usage which may be readily identifiable, suggesting that an energy audit be conducted, and identifying sources of energy conservation information and financial assistance which may be available to the customer.

f. A utility may disconnect electric service after 24-hour notice (and without the written 12-day notice) for failure of the customer to comply with the terms of a payment agreement.

g. The utility shall, prior to November 1, mail customers a notice describing the availability of winter energy assistance funds and the application process. The notice must be of a type size that is easily legible and conspicuous and must contain the information set out by the state agency administering the assistance program. A utility serving fewer than 25,000 customers may publish the notice in a customer newsletter in lieu of mailing. A utility serving fewer than 6,000 customers may publish the notice in an advertisement in a local newspaper of general circulation or shopper's guide.

20.4(16) *Insufficient reasons for denying service.* The following shall not constitute sufficient cause for refusal of service to a customer:

a. Delinquency in payment for service by a previous occupant of the premises to be served.

b. Failure to pay for merchandise purchased from the utility.

c. Failure to pay for a different type or class of public utility service.

d. Failure to pay the bill of another customer as guarantor thereof.

e. Failure to pay the back bill rendered in accordance with paragraph 20.4(14)*"d"* (slow meters).

f. Failure to pay a bill rendered in accordance with paragraph 20.4(14)*"f."*

g. Failure of a residential customer to pay a deposit during the period November 1 through April 1 for the location at which the customer has been receiving service.

h. Delinquency in payment for service by an occupant if the customer applying for service is creditworthy and able to satisfy any deposit requirements.

20.4(17) *When disconnection prohibited.*

a. No disconnection may take place from November 1 through April 1 for a resident who has been certified to the public utility by the local community action agency as being eligible for either the low-income home energy assistance program or weatherization assistance program.

b. If the utility is informed that one of the heads of household as defined in Iowa Code section 476.20 is a service member deployed for military service, as defined in Iowa Code section 29A.90, disconnection cannot take place at the residence during the deployment or prior to 90 days after the end of the deployment.

20.4(18) *Estimated demand.* Upon request of the customer and provided the customer's demand is estimated for billing purposes, the utility shall measure the demand during the customer's normal operation and use the measured demand for billing.

20.4(19) *Servicing utilization control equipment.* Each utility shall service and maintain any equipment it uses on customer's premises and shall correctly set and keep in proper adjustment any thermostats, clocks, relays, time switches or other devices which control the customer's service in accordance with the provisions in the utility's rate schedules.

20.4(20) *Customer complaints.* Complaints concerning the charges, practices, facilities or service of the utility shall be investigated promptly and thoroughly. The utility shall keep such records of customer complaints as will enable it to review and analyze its procedures and actions.

a. Each utility shall provide in its filed tariff a concise, fully informative procedure for the resolution of customer complaints.

b. The utility shall take reasonable steps to ensure that customers unable to travel shall not be denied the right to be heard.

c. The final step in a complaint hearing and review procedure shall be a filing for board resolution of the issues.

20.4(21) *Temporary service.* When the utility renders temporary service to a customer it may require that the customer bear all of the cost of installing and removing the service facilities in excess of any salvage realized.

20.4(22) *Change in type of service.* If a change in the type of service, such as from 25- to 60-cycle or from direct or alternating current, or a change in voltage to a customer's substation, is effected at the insistence of the utility and not solely by reason of increase in the customer's load or change in the character thereof, the utility shall share equitably in the cost of changing the equipment of the customer affected as determined by the board in the absence of agreement between utility and customer. In general, the customer should be protected against or reimbursed for the following losses and expenses to an appropriate degree:

a. Loss of value in electrical power utilization equipment.

b. Cost of changes in wiring, and

c. Cost of removing old and installing new utilization equipment.

20.4(23) *Limitation of service.* The utility shall have the option of adopting a policy for service limitation at a customer's residence as a measure to be taken in lieu of disconnection of service to the customer. The service limiter policy shall be set out in the utility's tariff and shall contain the following conditions:

a. A service limitation device shall not be activated without the customer's agreement.

b. A service limitation device shall not be activated unless the customer has defaulted on all payment agreements for which the customer qualifies under the board's rules and the customer has agreed to a subsequent payment agreement.

c. The service limiter shall provide for usage of a minimum of 3,600 watts. If the service limiter policy provides for different usage levels for different customers, the tariff shall set out specific nondiscriminatory criteria for determining the usage levels. Electric-heating residential customers may have their service limited if otherwise eligible, but such customers shall have consumption limits set at a level that allows them to continue to heat their residences. For purposes of this rule, "electric heating" shall mean heating by means of a fixed-installation electric appliance that serves as the primary source of heat and not, for example, one or more space heaters.

d. A provision that, if the minimum usage limit is exceeded such that the limiter function interrupts service, the service limiter function must be capable of being reset manually by the customer, or the service limiter function must reset itself automatically within 15 minutes after the interruption. In addition, the service limiter function may also be capable of being reset remotely by the utility. If the utility chooses to use the option of resetting the meter remotely, the utility shall provide a 24-hour toll-free number for the customer to notify the utility that the limiter needs to be reset and the meter shall be reset immediately following notification by the customer. If the remote reset option is used, the meter must still be capable of being reset manually by the customer or the service limiter function must reset itself automatically within 15 minutes after the interruption.

e. There shall be no disconnect, reconnect, or other charges associated with service limiter interruptions or restorations.

f. A provision that, upon installation of a service limiter or activation of a service limiter function on the meter, the utility shall provide the customer with information on the operation of the limiter, including how it can be reset, and information on what appliances or combination of appliances can generally be operated to stay within the limits imposed by the limiter.

g. A provision that the service limiter function of the meter shall be disabled no later than the next working day after the residential customer has paid the delinquent balance in full.

h. A service limiter customer that defaults on the payment agreement is subject to disconnection after a 24-hour notice pursuant to paragraph 20.4(15)*"f."*

[**ARC 7976B**, IAB 7/29/09, effective 9/2/09; **ARC 9101B**, IAB 9/22/10, effective 10/27/10; Editorial change: IAC Supplement 12/29/10]

These rules are intended to implement Iowa Code sections 476.6, 476.8, 476.20 and 476.54.

199—20.5(476) Engineering practice.

20.5(1) *Requirement for good engineering practice.* The electric plant of the utility shall be constructed, installed, maintained and operated in accordance with accepted good engineering practice in the electric industry to assure, as far as reasonably possible, continuity of service, uniformity in the quality of service furnished, and the safety of persons and property.

20.5(2) *Standards incorporated by reference.* The utility shall use the applicable provisions in the publications listed below as standards of accepted good practice unless otherwise ordered by the board.

a. Iowa Electrical Safety Code, as defined in 199 IAC Chapter 25.

b. National Electrical Code, ANSI/NFPA 70-2008.

c. American National Standard Requirements for Instrument Transformers, ANSI/IEEE C57.13.1-2006; and C57.13.3-2006.

d. American National Standard for Electric Power Systems and Equipment Voltage Ratings (60 Hertz), ANSI C84.1-2006.

e. Grounding of Industrial and Commercial Power Systems, IEEE 142-2007.

f. IEEE Standard 1159-1995, IEEE Recommended Practice for Monitoring Electric Power Quality or any successor standard.

g. IEEE Standard 519-1992, IEEE Recommended Practices and Requirements for Harmonic Control in Electrical Power Systems or its successor standard.

h. At railroad crossings, 199 IAC 42.6(476), "Engineering standards for electric and communications lines."

20.5(3) *Adequacy of supply and reliability of service.* The generating capacity of the utility's plant, supplemented by the electric power regularly available from other sources, must be sufficiently large to meet all normal demands for service and provide a reasonable reserve for emergencies.

In appraising adequacy of supply the board will segregate electric utilities into two classes viz., those having high capacity transmission interconnections with other electrical utilities and those which lack such interconnection and are therefore completely dependent upon the firm generating capacity of the utility's own generating facilities.

a. In the case of utilities having interconnecting ties with other utilities, the board will, upon appraising adequacy of supply, take appropriate notice of the utility's recent past record, as of the

date of appraisal, of any widespread service interruptions and any capacity shortages along with the consideration of the supply regularly available from other sources, the normal demands, and the required reserve for emergencies.

b. In the case of noninterconnected utilities the board will give attention to the maximum total coincident customer demand which could be satisfied without the use of the single element of plant equipment, the disability of which would produce the greatest reduction in total net plant productive capacity and also give attention to the normal demands for service and to the reasonable reserve for emergencies.

20.5(4) *Electric transmission and distribution facilities.* Rescinded IAB 11/13/02, effective 12/18/02.

20.5(5) *Inspection of electric plant.* Each utility shall adopt a written program for inspection of its electric plant in order to determine the necessity for replacement and repair in compliance with board rule 199—25.3(476,478).

This rule is intended to implement Iowa Code section 476.8 and 478.18.

[**ARC 7962B**, IAB 7/15/09, effective 8/19/09]

199—20.6(476) Metering.

20.6(1) *Inspection and testing program.* Each utility shall adopt a written program for the inspection and testing of its meters to determine the necessity for adjustment, replacement or repair. The frequency of inspection and methods of testing shall be based on the utility's experience, manufacturer's recommendations, and accepted good practice. The publications listed in 20.6(3) are representative of accepted good practice. Each utility shall maintain inspecting and testing records for each meter and associated device until three years after its retirement.

20.6(2) *Program content.* The written program shall, at minimum, address the following subject areas:

a. Classification of meters by capacity, type, and any other factor considered pertinent.

b. Checking of new meters for acceptable accuracy before being placed in service.

c. Testing of in-service meters, including any associated instruments or corrective devices, for accuracy, adjustments or repairs. This may be accomplished by periodic tests at specified intervals or on the basis of a statistical sampling plan, but shall include meters removed from service for any reason.

d. Periodic calibration or testing of devices or instruments used by the utility to test meters.

e. The limits of meter accuracy considered acceptable by the utility.

f. The nature of meter and meter test records which will be maintained by the utility.

20.6(3) *Accepted good practice.* The following publications are considered to be representative of accepted good practice in matters of metering and meter testing:

a. American National Standard Code for Electricity Metering, ANSI C12.1-2008.

b. and *c.* Rescinded IAB 5/23/07, effective 6/27/07.

20.6(4) *Meter adjustment.* All meters and associated metering devices shall, when tested, be adjusted as closely as practicable to the condition of zero error.

20.6(5) *Request tests.* Upon request by a customer, a utility shall test the meter servicing that customer. A test need not be made more frequently than once in 18 months.

A written report of the test results shall be mailed to the customer within ten days of the completed test and a record of each test shall be kept on file at the utility's office. The utility shall give the customer or a representative of the customer the opportunity to be present while the test is conducted.

If the test finds the meter is accurate within the limits accepted by the utility in its meter inspection and testing program, the utility may charge the customer $25 or the cost of conducting the test, whichever is less. The customer shall be advised of any potential charge before the meter is removed for testing.

20.6(6) *Referee tests.* Upon written request by a customer or utility, the board will conduct a referee test of a meter. A test need not be made more frequently than once in 18 months. The customer request shall be accompanied by a $30 deposit in the form of a check or money order made payable to the utility.

Within five days of receipt of the written request and payment, the board shall forward the deposit to the utility and notify the utility of the requirement for a test. The utility shall, within 30 days after

notification of the request, schedule the date, time and place of the test with the board and customer. The meter shall not be removed or adjusted before the test. The utility shall furnish all testing equipment and facilities for the test. If the tested meter is found to be more than 2 percent fast or 2 percent slow, the deposit will be returned to the party requesting the test and billing adjustments shall be made as required in 20.4(14). The board shall issue its report within 15 days after the test is conducted, with a copy to the customer and the utility.

20.6(7) *Condition of meter.* No meter that is known to be mechanically or electrically defective, or to have incorrect constants, or that has not been tested and adjusted if necessary in accordance with these rules shall be installed or continued in service. The capacity of the meter and the index mechanism shall be consistent with the electricity requirements of the customer.

[**ARC 7962B**, IAB 7/15/09, effective 8/19/09]

199—20.7(476) Standards of quality of service.

20.7(1) Standard frequency. The standard frequency for alternating current distribution systems shall be 60 cycles per second. The frequency shall be maintained within limits which will permit the satisfactory operation of customer's clocks connected to the system.

20.7(2) Voltage limits retail. Each utility supplying electric service to ultimate customers shall provide service voltages in conformance with the standard at 20.5(2)*"d."*

20.7(3) Voltage balance. Where three-phase service is provided the utility shall exercise reasonable care to assure that the phase voltages are in balance. In no case shall the ratio of maximum voltage deviation from average to average voltage exceed .02.

20.7(4) Voltage limits, service for resale. The nominal voltage shall be as mutually agreed upon by the parties concerned. The allowable variation shall not exceed 7.5 percent above or below the agreed-upon nominal voltage without the express approval of the board.

20.7(5) Exceptions to voltage requirements. Voltage outside the limits specified will not be considered a violation when the variations:

a. Arise from the action of the elements.

b. Are infrequent fluctuations not exceeding five minutes, duration.

c. Arise from service interruptions.

d. Arise from temporary separation of parts of the system from the main system.

e. Are from causes beyond the control of the utility.

f. Do not exceed 10 percent above or below the standard nominal voltage, and service is at a distribution line or transmission line voltage with the retail customer providing voltage regulators.

20.7(6) Voltage surveys and records. Voltage measurements shall be made at the customer's entrance terminals. For single-phase service the measurement shall be made between the grounded conductor and the ungrounded conductors. For three-phase service the measurement shall be made between the phase wires.

20.7(7) Each utility shall make a sufficient number of voltage measurements, using recording voltmeters, in order to determine if voltages are in compliance with the requirements as stated in 20.7(2), 20.7(3), 20.7(4). All voltmeter records obtained under 20.7(7) shall be retained by the utility for at least two years and shall be available for inspection by the board's representatives. Notations on each chart shall indicate the following:

a. The location where the voltage was taken.

b. The time and date of the test.

c. The results of the comparison with a working standard indicating voltmeter.

20.7(8) Equipment for voltage measurements.

a. Secondary standard indicating voltmeter. Each utility shall have available at least one indicating voltmeter maintained with error no greater than 0.25 percent of full scale.

b. Working standard indicating voltmeters. Each utility shall have at least two indicating voltmeters maintained so as to have as-left errors of no greater than 1 percent of full scale.

c. Recording voltmeters. Each utility must have readily available at least two portable recording voltmeters with a rated accuracy of 1 percent of full scale.

20.7(9) Rescinded IAB 12/11/91, effective 1/15/92.

20.7(10) Extreme care must be exercised in the handling of standards and instruments to assure that their accuracy is not disturbed. Each standard shall be accompanied at all times by a certificate or calibration card, duly signed and dated, on which are recorded the corrections required to compensate for errors found at the customary test points at the time of the last previous test.

20.7(11) Planned interruptions shall be made at a time that will not cause unreasonable inconvenience to customers, and interruptions planned for longer than one hour shall be preceded by adequate notice to those who will be affected.

20.7(12) Power quality monitoring. Each utility shall investigate power quality complaints from its customers and determine if the cause of the problem is on the utility's systems. In addressing these problems, each utility shall implement to the extent reasonably practical the practices outlined in the standard given at 20.5(2)*"f."*

20.7(13) Harmonics. A harmonic is a sinusoidal component of the 60 cycles per second fundamental wave having a frequency that is an integral multiple of the fundamental frequency. When excessive harmonics problems arise, each electric utility shall investigate and take actions to rectify the problem. In addressing harmonics problems, the utility and the customer shall implement to the extent practicable and in conformance with prudent operation the practices outlined in the standard at 20.5(2)*"g."*

This rule is intended to implement Iowa Code sections 476.2 and 476.8.

199—20.8(476) Safety.

20.8(1) *Protective measures.* Each utility shall exercise reasonable care to reduce those hazards inherent in connection with its utility service and to which its employees, its customers, and the general public may be subjected and shall adopt and execute a safety program designed to protect the public and fitted to the size and type of its operations.

20.8(2) *Accident investigation and prevention.* The utility shall give reasonable assistance to the board in the investigation of the cause of accidents and in the determination of suitable means of preventing accidents.

20.8(3) *Reportable accidents.* Each utility shall maintain a summary of all reportable accidents, as defined in 199—25.5(476,478), arising from its operations.

20.8(4) *Grounding of secondary distribution system.* Unless otherwise specified by the board, each utility shall comply with, and shall encourage its customers to comply with, the applicable provisions of the acceptable standards listed in 20.5(2) for the grounding of secondary circuits and equipment.

Ground connections should be tested for resistance at the time of installation. The utility shall keep a record of all ground resistance measurements.

The utility shall establish a program of inspection so that all artificial grounds installed by it shall be inspected within reasonable periods of time.

199—20.9(476) Electric energy sliding scale or automatic adjustment. A rate-regulated utility's sliding scale or automatic adjustment of the unit charge for electric energy shall be an energy clause.

20.9(1) *Applicability.* A rate-regulated utility's sliding scale or automatic adjustment of electric utility energy rates shall recover from consumers only those costs which:

Are incurred in supplying energy;

Are beyond direct control of management;

Are subject to sudden important change in level;

Are an important factor in determining the total cost to serve; and

Are readily, precisely, and continuously segregated in the accounts of the utility.

20.9(2) *Energy clause for rate-regulated utility.* Prior to each billing cycle, a rate-regulated utility shall determine and file for board approval the adjustment amount to be charged for each energy unit consumed under rates set by the board. The filing shall include all journal entries, invoices (except invoices for fuel, freight, and transportation), worksheets, and detailed supporting data used to determine the amount of the adjustment. The estimated amount of fossil fuel should be detailed to reflect the amount of fuel, transportation, and other costs.

The journal entries should reflect the following breakdown for each type of fuel: actual cost of fuel, transportation, and other costs. Items identified as other costs should be described and their inclusion as fuel costs should be justified. The utility shall also file detailed supporting data:

1. To show the actual amount of sales of energy by month for which an adjustment was utilized, and

2. To support the energy cost adjustment balance utilized in the monthly energy adjustment clause filings.

a. The energy adjustment shall provide for change of the price per kilowatt hour consumed under rates set by the board based upon the formulas provided below. The calculation shall be:

$$E_0 = \frac{EC_0 + EC_1}{EQ_0 + EQ_1} + \frac{A_1}{EJ_0 + EJ_1} - B$$

E_0 is the energy adjustment charge to be used in the next customer billing cycle rounded on a consistent basis to either the nearest 0.01¢/kWh or 0.001¢/kWh. For deliveries at voltages higher than secondary line voltages, appropriate factors should be applied to the adjustment charge to recognize the lower losses associated with these deliveries.

EC_0 is the estimated expense for energy in the month during which E_0 will be used.

EC_1 is the estimated expense for energy in the month prior to the month of EC_0.

EQ_0 is the estimated electric energy to be consumed or delivered and entered in accounts 440, 442, 444-7, excluding energy from distinct interchange deliveries entered into account 447 and including intrautility energy service as included in accounts 448 and 929 of the Uniform System of Accounts during the month in which E_0 will be used.

EQ_1 is the estimated electric energy to be consumed or delivered and entered in accounts 440, 442, 444-7, excluding energy from distinct interchange deliveries entered in account 447 and including intrautility energy service as included in accounts 448 and 929 of the Uniform System of Accounts during the month prior to EQ_0.

EJ_0 is the estimated electric energy to be consumed under rates set by the board in the month during which the energy adjustment charge (E_0) will be used in bill calculations.

EJ_1 is the estimated electric energy to be consumed under rates set by the board in the month prior to the month of EJ_0.

A_1 is the beginning of the month energy cost adjustment account balance for the month of estimated consumption EJ_1. This would be the most recent month's balance available from actual accounting data.

B is the amount of the electric energy cost included in the base rates of a utility's rate schedules.

b. The estimated energy cost ($EC_0 + EC_1$) shall be the estimated cost associated with EQ_0 and EQ_1 determined as the cost of:

(1) Fossil and nuclear fuel consumed in the utility's own plants and the utility's share of fossil and nuclear fuel consumed in jointly owned or leased plants. Fossil fuel shall include natural gas used for electric generation and the cost of fossil fuel transferred from account 151 to account 501 or 547 of the Uniform System of Accounts for Electric Utilities. Nuclear fuel shall be that shown in account 518 of the Uniform System of Accounts except that if account 518 contains any expense for fossil fuel which has already been included in the cost of fossil fuel, it shall be deducted from the account. (Paragraph C of account 518 includes the cost of other fuels used for ancillary steam facilities.)

(2) The cost of steam purchased, or transferred from another department of the utility or from others under a joint facility operating agreement, for use in prime movers producing electric energy (accounts 503 and 521).

(3) A deduction shall be made of the expenses of producing steam chargeable to others, to other utility departments under a joint operating agreement, or to other electric accounts outside the steam generation group of accounts (accounts 504 and 522).

(4) The cost of water used for hydraulic power generation. Water cost shall be limited to items of account 536 of the Uniform System of Accounts. For pumped storage projects the energy

cost of pumping is included. Pumping energy cost shall be determined from the applicable costs of subparagraphs of paragraph 20.9(2)*"b."*

(5) The energy costs paid for energy purchased under arrangements or contracts for firm power, operational control energy, outage energy, participation power, peaking power, and economy energy, as entered into account 555 of the Uniform System of Accounts, less the energy revenues to be recovered from corresponding sales, as entered in account 447 of the Uniform System of Accounts.

(6) Purchases from AEP facilities under rule 199—15.11(476).

(7) The weighted average costs of inventoried allowances used in generating electricity.

(8) The gains and losses, as described in subrule 20.17(9), from allowance transactions occurring during the month. Allowance transactions shall include vintage trades and emission for emission trades.

(9) Eligible costs or credits associated with the utility's annual reconciliation of its alternate energy purchase program under 199—paragraph 15.17(4)*"b."*

c. The energy cost adjustment account balance (A) shall be the cumulative balance of any excess or deficiency which arises out of the difference between board recognized energy cost recovery and the amount recovered through application of energy charges to consumption under rates set by the board. Each monthly entry (D) into the energy cost adjustment account shall be the dollar amount determined from solution of the following equation (with proper adjustment for those deliveries at high voltage which for billing purposes recognized the lower losses associated with the high voltage deliveries).

$$D = \left[C_2 \times \frac{J_2}{Q_2} \right] - \left[J_2 \times (E_2 + B) \right]$$

C_2 is the actual expense for energy, calculated as set forth in 20.9(2)*"b,"* in the month prior to EJ_1 of 20.9(2)*"a."*

J_2 is the actual energy consumed in the prior month under rates set by the board and recorded in accounts 440, 442 and 444-6 of the Uniform System of Accounts.

Q_2 is the actual total energy consumed or delivered in the prior month and recorded in accounts 440, 442, 444-7, excluding energy from distinct interchange deliveries entered in account 447, and including intrautility energy service as included in accounts 448 and 929 of the Uniform System of Accounts.

E_2 is the energy adjustment charge used for billing in the prior month.

B is the amount of the electric energy cost included in the base rates of a utility's rate schedules.

d. Reserve account for nuclear generation. A rate-regulated utility owning nuclear generation or purchasing energy under a participation power agreement on nuclear generation may establish a reserve account. The reserve account will spread the higher cost of energy used to replace that normally received from nuclear sources. A surcharge would be added to each kilowatt hour from the nuclear source. The surcharges collected are credited to the reserve account. During an outage or reduced level of operation, replacement energy cost would be offset through debit to the reserve account. The debit would be based upon the cost differential between replacement energy cost and the average cost (including the surcharge) of energy from the nuclear capacity. A reserve account shall have credit and debit limitations equal in dollar amounts to the total cost differential for replacement energy during a normal refueling outage.

e. A rate-regulated utility desiring to collect expensed allowance costs and the gains and losses from allowance transactions through the energy adjustment must file with the board monthly reports including:

(1) The number and weighted average unit cost of allowances used during the month to offset emissions from the utility's affected units;

(2) The number and unit price of allowances purchased during the month;

(3) The number and unit price of allowances sold during the month;

(4) The weighted average unit cost of allowances remaining in inventory;

(5) The dollar amount of any gain from an allowance sale occurring during the month;

(6) The dollar amount of any loss from an allowance sale occurring during the month; and

(7) Documentation of any gain or loss from an allowance sale occurring during the month.

f. A rate-regulated utility which proposes a new sliding scale or automatic adjustment clause of electric utility energy rates shall conform such clause with the rules.

20.9(3) *Optional energy clause for a rate-regulated utility which does not own generation.* A rate-regulated utility which does not own generation may adopt the energy adjustment clause of this subrule in lieu of that set forth in subrule 20.9(2). Prior to each billing cycle it shall determine and file for board approval the adjustment amount to be charged for each energy unit consumed under rates set by the board. The filing shall include all journal entries, invoices (except invoices for fuel, freight, and transportation), worksheets, and detailed supporting data used to determine the amount of the adjustment. The estimated amount of fossil fuel should be detailed to reflect the amount of fuel, transportation, and other costs.

The journal entries should reflect the following breakdown for each type of fuel: actual cost of fuel, transportation, and other costs. Items identified as other costs should be described and their inclusion as fuel costs should be justified. The utility shall also file detailed supporting data:

1. To show the actual amount of sales of energy by month for which an adjustment was utilized, and
2. To support the energy cost adjustment balance utilized in the monthly energy adjustment clause filings.

a. The energy adjustment charge shall provide for change of the price per kilowatt-hour consumed to equal the average cost per kilowatt hour delivered by the utility's system. The calculation shall be:

$$E_0 = \frac{C_2 + C_3 + C_4}{Q_2 + Q_3 + Q_4} - B$$

E_0 is the energy adjustment charge to be used in the next customer billing cycle rounded on a consistent basis to either the nearest 0.01¢/kWh or 0.001¢/kWh. For deliveries at voltages higher than secondary line voltages, appropriate factors should be applied to the adjustment charge to recognize the lower losses associated with these deliveries.

C_2, C_3 and C_4 are the charges by the wholesale suppliers as recorded in account 555 offset by energy revenues from distinct interchange deliveries entered in account 447 of the Uniform System of Accounts for the first three of the four months prior to the month in which E_0 will be used.

Q_2, Q_3 and Q_4 are the total electric energy delivered by the utility system, excluding energy from distinct interchange deliveries entered in account 447 during each of the months in which the expenses C_2, C_3 and C_4 were incurred.

B is the amount of the electric energy cost included in the base rates of a utility's rate schedules.

b. A utility purchasing its total electric energy requirements may establish an energy cost adjustment account for which the cumulative balance is the excess or deficiency arising from the difference between commission-recognized energy cost recovery and the amount recovered through application of energy charges on jurisdictional consumption.

For a utility electing to use an energy cost adjustment account the calculation shall be:

$$E_0 = \frac{C_2 + C_3 + C_4}{Q_2 + Q_3 + Q_4} + \frac{A_2}{J_2 + J_3 + J_4} - B$$

E_0 is the energy adjustment charge to be used in the next customer billing cycle rounded on a consistent basis to either the nearest 0.01¢/kWh or 0.001¢/kWh. For deliveries at voltages higher than secondary line voltages, appropriate factors should be applied to the adjustment charge to recognize the lower losses associated with these deliveries.

C_2, C_3 and C_4 are the charges by the wholesale suppliers as recorded in account 555 offset by energy revenues from distinct interchange deliveries entered in account 447 of the Uniform System of Accounts for the first three of the four months prior to the month in which E_0 will be used.

Q_2, Q_3 and Q_4 are the total electric energy delivered by the utility system, excluding energy from distinct interchange deliveries entered in account 447 during each of the months in which the expenses C_2, C_3 and C_4 were incurred.

A_2 is the end of the month energy cost adjustment account balance for the month of consumption J_2. This would be the most recent month's balance available from actual accounting data.

J_2, J_3 and J_4 are electric energy consumed under rates set by the board in the months corresponding to C_2, C_3 and C_4.

B is the amount of the electric energy cost included in the base rates of a utility's rate schedules.

c. The end of the month energy cost adjustment account balance (A) shall be the cumulative balance of any excess or deficiency which arises out of the difference between board recognized energy cost recovery and the amount recovered through application of energy charges to consumption under rates set by the board.

Each monthly entry (D) into the energy cost adjustment account shall be the dollar amount determined from solution of the following equation (with proper adjustment for those deliveries at high voltage which for billing purposes recognized the lower losses associated with the high voltage deliveries).

$$D = \left[C_2 \times \frac{J_2}{Q_2} \right] - \left[J_2 \times (E_2 + B) \right]$$

C_2 is the prior month charges by the wholesale suppliers as recorded in account 555 of the Uniform System of Accounts offset by energy revenues from distinct interchange deliveries entered in account 447.

J_2 is the electric energy consumed under jurisdictional rates in the prior month.

Q_2 is the electric energy delivered by the utility system, excluding energy from distinct interchange deliveries entered in account 447 in the prior month.

E_2 is the energy adjustment charge used for billing in the prior month.

B is the amount of the electric energy cost included in the base rates of a utility's rate schedules.

d. A utility with special conditions may petition the board for a waiver which would recognize its unique circumstances.

e. A utility which does not own generation and proposes a new sliding scale or automatic adjustment clause of electric utility rates shall conform such clause with the rules.

20.9(4) *Annual review of energy clause.* On or before each May 1, the board will notify each utility as to the two months of the previous calendar year for which fuel, freight, and transportation invoices will be required. Two copies of these invoices shall be filed with the board no later than the subsequent November 1.

This rule is intended to implement Iowa Code section 476.6(11).

199—20.10(476) Ratemaking standards.

20.10(1) *Coverage.* Standards for ratemaking shall apply to all rate-regulated utilities in the state of Iowa. The board may, by rule or by order in specific cases, exempt a utility or class of utilities from any or all ratemaking standards. The standards are recommended to all service-regulated utilities in this jurisdiction.

20.10(2) *Cost of service.* Rates charged by an electric utility for providing electric service to each class of electric consumers shall be designed, to the maximum extent practicable, to reasonably reflect the costs of providing electric service to the class. The methods used to determine class costs of service shall to the maximum extent practical permit identification of differences in cost-incurrence, for each class of electric consumers, attributable to daily and seasonal time of use of service, and permit identification of differences in cost-incurrence attributable to differences in demand, energy, and customer components of cost.

The design of rates should reasonably approximate a pricing methodology for any individual utility that would reflect the price system that would exist in a competitive market environment. For purposes

of determining revenue requirements among customer classes, embedded costs shall be preferred. For purposes of determining rate designs within customer classes, long-run marginal cost approaches are preferred although embedded cost approaches may be considered reasonable.

Nothing in this rule shall authorize or require the recovery by an electric utility of revenues in excess of, or less than, the amount of revenues otherwise determined to be lawful by the board.

Guidelines for use in evaluating the acceptability of methods of class cost of service estimation include, but are not limited to, the following:

a. All usage of customer, demand, and energy components of service shall be considered new usage.

b. Customer classes shall be established on the primary basis of reasonably similar usage patterns within classes, even if this requires disaggregation or recombination of traditional customer classes.

c. Generating capacity estimates or allocations among and within classes shall recognize that utility systems are designed to serve both peak and off-peak demand, and shall attribute costs based upon both peak period demand and the contribution of off-peak period demand in determining generation mix. Generating capacity estimates and allocations among and within classes shall be based on load data for each class as described in 199—subrule 35.9(2).

d. Transmission and distribution capacity estimates or allocations among and within classes shall be demand-related based upon system usage patterns, and the load imposed by a class on the transmission or distribution capacity in question.

e. Customer cost component estimates or allocations shall include only costs of the distribution system from and including transformers, meters and associated customer service expenses.

f. Methods of cost estimates or allocations among customer classes shall recognize the differences in voltage levels and other service characteristics, and line losses among customer classes.

g. Methods of class cost of service determination which are consistent with zero customer, demand, or energy component costs or major categories of these, such as generation, transmission or distribution, shall be considered unacceptable methods.

h. Long-run marginal cost methods of class cost of service determination shall clearly reflect changes in total costs to the utility with respect to changes in the outputs of customer, demand, or energy components of electric services.

i. The use of an inverse elasticity approach to adjust long-run marginal cost-based rates to the revenue requirement shall be unacceptable. Other approaches will be considered on a case-by-case basis.

20.10(3) *Declining block rates.* The energy-related cost component of a rate, or the amount attributable to the energy-related cost component of a rate, charged by an electric utility for providing electric service during any period to any class of electric consumers, shall not decrease as kilowatt-hour consumption by such class increases during the period except to the extent that the utility demonstrates that the energy costs of providing electric service to such class decrease as consumption increases during the period.

20.10(4) *Time-of-day rates.* The rates charged by any electric utility for providing electric service to each class of electric consumers shall be on a time-of-day basis which reflects the cost of providing electric service to that class of electric consumers at different times of the day unless such rates are not cost-effective with respect to the class. These rates are cost-effective with respect to a class if the long-run benefits of the rate to the electric utility and its electric consumers in the class concerned are likely to exceed the metering costs and other costs associated with the use of the rates. Cost-based time-of-day rates shall be offered on an optional basis to electric consumers who do not otherwise qualify for the rates if consumers agree to pay the additional metering costs and other costs associated with the use of the rates.

20.10(5) *Seasonal rates.* The rates charged by an electric utility for providing electric service to each class of electric consumers may be on a seasonal basis which reflects the costs of providing service to the class of consumers at different seasons of the year to the extent that costs vary seasonally for the utility, if the board determines that seasonal rates are appropriate in an individual case.

20.10(6) *Interruptible rates.* Each electric utility shall offer each industrial and commercial electric consumer an interruptible rate which reflects the cost of providing interruptible service to the class of which the consumer is a member.

20.10(7) *Load management techniques.* Rescinded IAB 11/12/03, effective 12/17/03.

20.10(8) *Other energy conservation strategies.* Rescinded IAB 11/12/03, effective 12/17/03.

20.10(9) *Pilot projects.* Rescinded IAB 11/12/03, effective 12/17/03.

199—20.11(476) Customer notification of peaks in electric energy demand. Each electric utility shall inform its customers of the significance of reductions in consumption of electricity during hours of peak demand.

20.11(1) *Annual notice.* Each electric utility shall provide its customers, on an annual basis, with a written notice explaining how growth in demand affects a utility's investment costs and why reduction of customer usage during periods of peak demand may help delay or reduce the amount of future rate increases. The notice shall be delivered to its customers between May 1 and June 15 of each year if peak demand is likely to occur during the months of June through September. If peak demand usually occurs during the months of October through February, the notice shall be delivered to its customers between August 1 and September 15.

20.11(2) *Notification plan.* Each investor-owned utility shall have on file with the board a plan to notify its customers of an approaching peak demand on the day when peak demand is likely to occur.

a. The plan shall include the following:

(1) A provision for a general notice to be given customers prior to the time when peak demand is likely to occur as prescribed in 20.11(2)*"b"* and an explanation of when and how notice of an approaching peak in electric demand will be given to customers.

(2) A provision for direct notice to be given customers whose load reduction will have a significant impact on the utility's peak. The utility shall provide for such notice to be given prior to the time when peak demand is likely to occur, as prescribed in 20.11(2)*"b,"* and shall explain the criteria used to identify customers to whom notice will be given and when and how notice will be given.

(3) A statement showing the total costs, with each component thereof itemized, projected to be associated with implementing the plan. Notice should be provided in the most efficient manner available. The board may reject a plan which includes excessive costs or which specifies an ineffective method of customer notification and may direct development of a new plan.

(4) The text of the general and direct message to be given in the general notice to customers. The message shall, at a minimum, include the name of the utility or utilities providing the notice, an explanation that conditions exist which indicate a peak in demand is approaching, and a statement that reduction in usage of electricity during the period of peak demand will ease the burden placed on the utility's system by growth in peak demand and may help delay or reduce the amount of future rate increases.

(5) A designation of the U.S. weather station(s), situated within the utility's service territory, whose temperature readings and predictions will be used by the utility in applying the standard in 20.11(2)*"b."*

(6) A provision for joint delivery, by two or more utilities, of the general notice to customers in regions of the state where U.S. weather station(s) predict conditions specified in 20.11(2)*"b"* will exist on the same day.

b. For purposes of this rule, peak demand is likely to occur on a nonholiday weekday between June 15 and September 15 when the following conditions exist:

(1) The utility's designated weather station predicts the temperature will rise above 95° Fahrenheit (35° Celsius), and the designated weather station officially recorded a temperature above 95° Fahrenheit (35° Celsius) on the previous day, or

(2) The utility's designated weather station predicts the temperature will rise to above 90° Fahrenheit (33° Celsius) on a day following at least two consecutive days of temperatures above 95° Fahrenheit (35° Celsius), as officially recorded by the designated weather station, but

(3) If a utility can demonstrate it would have been required to provide between June 15 and September 15 a peak alert notice to customers, because of the existence of the conditions set forth in

20.11(2)*"b"*(1) or 20.11(2)*"b"*(2), on more than six days in any one of the preceding ten years, the utility may substitute a 97° Fahrenheit (36° Celsius) standard in lieu of the 95° Fahrenheit (35° Celsius) standard in the subrule.

20.11(3) *Implementation of notification plan.* The utility shall implement the approved plan on each day of the year when peak demand is likely to occur, as prescribed by 20.11(2)*"b."*

20.11(4) *Permissive notices.* The standard for implementing peak alert notification in subrule 20.11(2) is a minimum standard and does not prohibit a utility or association of utilities from issuing a notice requesting customers to reduce usage at any other time.

20.11(5) *Annual report.* Each electric utility required by subrule 20.11(2) to file a plan for customer notification shall file, on or before April 1 of each year, a report stating the number of notices given its customers, the dates when notices were issued, the annual cost of providing both general and direct notice to customers and measures of kilowatt hour demand at the time when notice was given and at hourly intervals thereafter until kilowatt hour demand decreases to the level at which it was measured when the notice was issued. The annual report shall also include a statement of any problems experienced by the utility in providing customer notification of a peak demand and a proposal to modify the plan, if necessary, to make customer notification more effective. Modifications must be approved by the board before they are implemented.

199—20.12(476) New structure energy conservation standards. Rescinded IAB 11/12/03, effective 12/17/03.

199—20.13(476) Periodic electric energy supply and cost review [476.6(16)].

20.13(1) *Procurement plan.* The board shall periodically conduct a contested case proceeding for the purpose of evaluating the reasonableness and prudence of a rate-regulated public utility's electric fuel procurement and contracting practices. By January 31 each year the board will notify a rate-regulated utility if the utility will be required to file an electric fuel procurement plan. In the years in which it does not conduct a contested case proceeding, the board may require a utility to file certain information for the board's review. In years in which a full proceeding is conducted, a rate-regulated utility providing electric service in Iowa shall prepare and file with the board on or before May 15 of each required filing year a complete electric fuel procurement plan for an annual period commencing June 1 or, in the alternative, for the annual period used by the utility in preparing its own fuel procurement plan. A utility's procurement plan shall be organized to include information as follows:

a. Index. The plan shall include an index of all documents and information required to be filed in the plan, and the identification of the board files in which the documents incorporated by reference are located.

b. Purchase contracts and arrangements. A utility's procurement plan shall include detailed summaries of the following types of contracts and agreements executed since the last procurement review:

(1) All contracts and fuel supply arrangements for obtaining fuel for use by any unit in generation;

(2) All contracts and arrangements for transporting fuel from point of production to the site where placed in inventory, including any unit generating electricity for the utility;

(3) All contracts and arrangements for purchasing or selling allowances;

(4) Purchased power contracts or arrangements, including sale-of-capacity contracts, involving over 25 MW of capacity;

(5) Pool interchange agreements;

(6) Multiutility transmission line interchange agreements; and

(7) Interchange agreements between investor-owned utilities, generation and transmission cooperatives, or both, not required to be filed above, which were entered into or in effect since the last filing, and all such contracts or arrangements which will be entered into or exercised by the utility during the prospective 12-month period.

All procurement plans filed by a utility shall include all of the types of contracts and arrangements listed in subparagraphs (1) and (2) of this paragraph which will be entered into or exercised by the utility

during the prospective 12-month period. In addition, the utility shall file an updated list of contracts that are or will become subject to renegotiation, extension, or termination within five years. The utility shall also update any price adjustment affecting any of the filed contracts or arrangements.

c. Other contract offers. The procurement plan shall include a list and description of those types of contracts and arrangements listed in paragraph 20.13(1)*"b"* offered to the utility since the last filing into which the utility did not enter. In addition, the procurement plan shall include a list of those types of contracts and arrangements listed in paragraph 20.13(1)*"b"* which were offered to the utility for the prospective 12-month period and into which the utility did not enter.

d. Studies or investigation reports. The procurement plans shall include all studies or investigation reports which have been considered by the utility in deciding whether to enter into any of those types of contracts or arrangements listed in paragraphs 20.13(1)*"b"* and *"c"* which will be exercised or entered into during the prospective 12-month period.

e. Price hedge justification. The procurement plan shall justify purchasing allowance futures contracts as a hedge against future price changes in the market rather than for speculation.

f. Actual and projected costs. The procurement plan shall include an accounting of the actual costs incurred in the purchase and transportation of fuel and the purchase of allowances for use in generating electricity associated with each contract or arrangement filed in accordance with paragraph 20.13(1)*"b"* for the previous 12-month period.

The procurement plan also shall include an accounting of all costs projected to be incurred by the utility in the purchase and transportation of fuel and the purchase of allowances for use in generating electricity associated with each contract or arrangement filed in accordance with paragraph 20.13(1)*"b"* in the prospective 12-month period.

If applicable, the reporting of transportation costs in the procurement plan shall include all known liabilities, including all unit train costs.

g. Costs directly related to the purchase of fuel. The utility shall provide a list and description of all other costs directly related to the purchase of fuels for use in generating electricity not required to be reported by paragraph *"f."*

h. Compliance plans. Each utility shall file its emissions compliance plan as submitted to the EPA. Revisions to the compliance plan shall be filed with each subsequent procurement plan.

i. Evidence submitted. Each utility shall submit all factual evidence and written argument in support of its evaluation of the reasonableness and prudence of the utility's procurement practice decisions in the manner described in its procurement plan. The utility shall file data sufficient to forecast fuel consumption at each generating unit or power plant for the prospective 12-month period. The board may require the submission of machine-readable data for selected computer codes or models.

j. Additional information. Each utility shall file additional information as ordered by the board.

20.13(2) *Periodic review proceeding.* The board shall periodically conduct a proceeding to evaluate the reasonableness and prudence of a rate-regulated utility's procurement practices. The prudence review of allowance transactions and accompanying compliance plans shall be determined on information available at the time the options or plans were developed.

a. On or before May 15 of a required filing year, each utility shall file prepared direct testimony and exhibits in support of its fuel procurement decisions and its fuel requirement forecast. This filing shall be in conjunction with the filing of the plans. The burden shall be on the utility to prove it is taking all reasonable actions to minimize its purchased fuel costs.

b. The board shall disallow any purchased fuel costs in excess of costs incurred under responsible and prudent policies and practices.

199—20.14(476) Flexible rates.

20.14(1) *Purpose.* This subrule is intended to allow electric utility companies to offer, at their option, incentive or discount rates to their customers.

20.14(2) *General criteria.*

a. Electric utility companies may offer discounts to individual customers, to selected groups of customers, or to an entire class of customers. However, discounted rates must be offered to all directly

competing customers in the same service territory. Customers are direct competitors if they make the same end product (or offer the same service) for the same general group of customers. Customers that only produce component parts of the same end product are not directly competing customers.

b. In deciding whether to offer a specific discount, the utility shall evaluate the individual customer's, group's, or class's situation and perform a cost-benefit analysis before offering the discount.

c. Any discount offered should be such as to significantly affect the customer's or customers' decision to stay on the system or to increase consumption.

d. The consequences of offering the discount should be beneficial to all customers and to the utility. Other customers should not be at risk of loss as a result of these discounts; in addition, the offering of discounts shall in no way lead to subsidization of the discounted rates by other customers in the same or different classes.

20.14(3) *Tariff requirements.* If a company elects to offer flexible rates, the utility shall file for review and approval tariff sheets specifying the general conditions for offering discounted rates. The tariff sheets shall include, at a minimum, the following criteria:

a. The cost-benefit analysis must demonstrate that offering the discount will be more beneficial than not offering the discount.

b. The ceiling for all discounted rates shall be the approved rate on file for the customer's rate class.

c. The floor for the discount rate shall be equal the energy costs and customer costs of serving the specific customer.

d. No discount shall be offered for a period longer than five years, unless the board determines upon good cause shown that a longer period is warranted.

e. Discounts should not be offered if they will encourage deterioration in the load characteristics of the customer receiving the discount.

20.14(4) *Reporting requirements.* Each rate-regulated electric utility electing to offer flexible rates shall file annual reports with the board within 30 days of the end of each 12 months. Reports shall include the following information:

a. Section 1 of the report concerns discounts initiated in the last 12 months. For all discounts initiated in the last 12 months, the report shall include:

(1) The identity of the new customers (by account number, if necessary);

(2) The value of the discount offered;

(3) The cost-benefit analysis results;

(4) The end-use cost of alternate fuels or energy supplies available to the customer, if relevant;

(5) The energy and demand components by month of the amount of electricity sold to the customer in the preceding 12 months.

b. Section 2 of the report relates to overall program evaluation. Amount of electricity refers to both energy and demand components when the customer is billed for both elements. For all discounts currently being offered, the report shall include:

(1) The identity of each customer (by account number, if necessary);

(2) The amount of electricity sold in the last 12 months to each customer at discounted rates, by month;

(3) The amount of electricity sold to each customer in the same 12 months of the preceding year, by month;

(4) The dollar value of the discount in the last 12 months to each customer, by month; and

(5) The dollar value of sales to each customer for each of the previous 12 months.

c. Section 3 of the report concerns discounts denied or discounts terminated. For all customers specifically evaluated and denied or having a discount terminated in the last 12 months, the report shall include:

(1) Customer identification (by account number, if necessary);

(2) The amount of electricity sold in the last 12 months to each customer, by month;

(3) The amount of electricity sold to each customer in the same 12 months of the preceding year, by month; and

(4) The dollar value of sales to each customer for each of the past 12 months.

d. No monthly report is required if the utility had no customers receiving a discount during the relevant period and had no customers which were evaluated for the discount and rejected during the relevant period.

20.14(5) *Rate case treatment.* In a rate case, 50 percent of any identifiable increase in net revenues will be used to reduce rates for all customers; the remaining 50 percent of the identifiable increase in net revenues may be kept by the utility. If there is a decrease in revenues due to the discount, the utility's test year revenues will be adjusted to remove the effects of the discount by assuming that all sales were made at full tariffed rates for the customer class. Determining the actual amount will be a factual determination to be made in the rate case.

199—20.15(476) Customer contribution fund.

20.15(1) *Applicability and purpose.* This rule applies to each electric public utility, as defined in Iowa Code sections 476.1, 476.1A, and 476.1B. Each utility shall maintain a program plan to assist the utility's low-income customers with weatherization and to supplement assistance received under the federal low-income home energy assistance program for the payment of winter heating bills.

20.15(2) *Program plan.* Each utility shall have on file with the board a detailed description of its current program plan. At a minimum, the plan shall include the following information:

a. A list of the members of the governing board, council, or committee established to determine the appropriate distribution of the funds collected. The list shall include the organization each member represents;

b. A sample of the customer notification with a description of the method and frequency of its distribution;

c. A sample of the authorization form provided to customers;

d. The date of implementation.

Program plans for new customer contribution funds shall be rejected if not in compliance with this rule.

20.15(3) *Notification.* Each utility shall notify all customers of the fund at least twice a year. The method of notice which will ensure the most comprehensive notification to the utility's customers shall be employed. Upon commencement of service and at least once a year, the notice shall be mailed or personally delivered to all customers. The other required notice may be published in a local newspaper(s) of general circulation within the utility's service territory. A utility serving fewer than 6000 customers may publish their semiannual notices locally in a free newspaper, utility newsletter or shopper's guide instead of a newspaper. At a minimum the notice shall include:

a. A description of the availability and the purpose of the fund;

b. A customer authorization form. This form shall include a monthly billing option and any other methods of contribution.

20.15(4) *Methods of contribution.* The utility shall provide for contributions as monthly pledges, as well as one-time or periodic contributions. Each utility may allow persons or organizations to contribute matching funds.

20.15(5) *Annual report.* On or before September 30 of each year, each utility shall file with the board a report of all the customer contribution fund activity for the previous fiscal year beginning July 1 and ending June 30. The report shall be in a form provided by the board and shall contain an accounting of the total revenues collected and all distributions of the fund. The utility shall report all utility expenses directly related to the customer contribution fund.

20.15(6) *Binding effect.* A pledge by a customer or other party shall not be construed to be a binding contract between the utility and the pledgor. The pledge amount shall not be subject to delayed payment charges by the utility.

199—20.16(476) Exterior flood lighting. Rescinded IAB 11/12/03, effective 12/17/03.

199—20.17(476) Ratemaking treatment of emission allowances.

20.17(1) *Applicability and purpose.* This rule applies to all rate-regulated utilities providing electric service in Iowa. Under Title IV of the Clean Air Act Amendments of 1990, each electric utility is required to hold sufficient emission allowances to offset emissions at all affected and new units. The acquisition and disposition of emission allowances will be treated for ratemaking purposes as defined in this rule.

20.17(2) *Definitions.* The following words and terms, when used in this rule, shall have the meaning indicated below:

"Allowance futures contract" is an agreement between a futures exchange clearinghouse and a buyer or seller to buy or sell an allowance on a specified future date at a specified price.

"Allowance option contract" is an agreement between a buyer and seller whereby the buyer has the option to transfer an allowance(s) at a specified date at a specified price. The seller of a call or put option will receive a premium for taking on the associated risk.

"Auction allowances" are allowances acquired or sold through EPA's annual allowance auction.

"Boot" means something acquired or forfeited to equalize a trade.

"Direct sale allowances" are allowances purchased from the EPA in its annual direct sale.

"Emission for emission trade" is an exchange of one type of emission for another type of emission. For example, the exchange of SO_2 emission allowances for NO_x emission allowances.

"Fair market value" is the amount at which an allowance could reasonably be sold in a transaction between a willing buyer and a willing seller other than in a forced or liquidation sale.

"Historical cost" is the amount of cash or its equivalent paid to acquire an asset, including any direct acquisition expenses. Any commissions paid to brokers shall be considered a direct acquisition expense.

"Original cost" is the historical cost of an asset to the person first devoting the asset to public service.

"Statutory allowances" are allowances allocated by the EPA at no cost to affected units under the Acid Rain Program either through annual allocations as a matter of statutory right and those for which a utility may qualify by using certain compliance options or effective use of conservation and renewables.

"Vintage trade" is an exchange of one vintage of allowances for another vintage of allowances with the difference in value between vintages being cash or additional allowances.

20.17(3) *Valuing allowances for ratemaking purposes.*

a. Statutory allowances. Valued at zero cost to electric utility.

b. Direct sale allowances. Valued at historical cost.

c. Auction allowances. Valued at historical cost.

d. Purchased allowances. Valued at historical cost.

20.17(4) *Valuing allowance inventory accounts.* Allowance inventory accounts shall be valued at the weighted average cost of all allowances eligible for use during that year.

20.17(5) *Valuing allowances acquired as part of a package.* Allowances acquired as part of a package with equipment, fuel, or electricity shall be valued at their fair market value at the time the allowances were acquired.

20.17(6) *Valuing allowances acquired through exchanges.*

a. Exchanges without boot. Electric utilities shall value allowances received in exchanges based on the recorded inventory value of the allowances relinquished.

b. Exchanges with boot. Electric utilities shall value allowances as the sum of the inventory cost of the allowances given up and the monetary consideration paid in boot for the newly acquired allowances. In determining the historical cost of allowances received, a gain (or loss) shall be recorded to the extent that the amount of boot received exceeds a proportionate share of the recorded weighted average inventory cost of the allowance surrendered. The proportionate share shall be based upon the ratio of the monetary consideration received (i.e., boot) to the total consideration received (monetary consideration plus the fair market value of the allowances received). The historical cost of the allowances received shall be equal to the amount derived by subtracting the difference between the boot received and the gain from the old inventory cost.

20.17(7) *Valuing allowances transferred among affiliates.*

a. Allowances transferred from a utility to a parent or unregulated subsidiary. Allowances shall be transferred at the higher of historical cost or fair market value.

b. Allowances transferred from an unregulated subsidiary or parent to a utility. Allowances shall be transferred at the lesser of original cost or fair market value.

c. Allowances transferred from a utility to an affiliated utility. Allowances shall be transferred at fair market value.

20.17(8) *Expense recognition and recovery of allowance costs.*

a. Expense recognition. Electric utilities shall charge allowances (including fractional amounts) to expense in the month in which related emissions occur.

b. Expense recovery. The expense associated with allowances used for compliance shall be passed through the energy adjustment as specified in rule 199—20.9(476). The expense associated with allowances used for compliance shall include expenses associated with vintage trades and emission for emission trades.

c. Allowance inventory shortage. If a utility emits more emissions in a month than it has allowances in inventory, the utility shall pass the estimated cost of acquiring the needed allowances through the energy adjustment. When the needed allowances are acquired, any difference between the estimated and actual cost of the allowances shall be passed through the energy adjustment as specified in rule 199—20.9(476).

20.17(9) *Gains/losses from allowance transactions.* The gains and losses, including net gains and losses, from allowance transactions shall be passed through the energy adjustment as specified in rule 20.9(476). Allowance transactions shall include vintage trades and emission for emission trades.

20.17(10) *Allowance futures or option contracts.*

a. Price hedging. Electric utilities shall defer the costs or benefits from hedging transactions and include such amounts in inventory values when the related allowances are acquired, sold, or otherwise disposed of. Where the costs or benefits of hedging transactions are not identifiable with specific allowances, the amounts shall be included in inventory values when the futures contract is closed.

b. Speculation. Allowance transactions entered into for the purpose of speculation shall not affect allowance inventory pricing.

20.17(11) *Working capital reserve of allowances.* A working capital reserve of allowances shall be established in each utility's rate case proceeding based on the probability of forced outages, fuel quality variability, variability in load growth, nuclear exposure, the price and availability of allowances on the national market, and any other factors that the board deems appropriate. The working capital reserve will earn at the utility's authorized rate of return.

20.17(12) *Allowances banked for future use.* Allowances banked for future use shall be considered plant held for future use in utility rate proceedings if a definitive plan and schedule for use of the allowances is deemed adequate by the board.

20.17(13) *Prudence of allowance transactions.* The prudence of allowance transactions shall be determined by the board in the periodic electric energy supply and cost review. The prudency review of allowance transactions and accompanying compliance plans shall be based on information available at the time the options or plans were developed. Costs recovered from ratepayers through the energy adjustment that are deemed imprudent by the board shall be refunded with interest to ratepayers through the energy adjustment as specified in rule 199—20.9(476).

199—20.18(476,478) Service reliability requirements for electric utilities.

20.18(1) *Applicability.* Rule 199—20.18(476,478) is applicable to investor-owned electric utilities and electric cooperative corporations and associations operating within the state of Iowa subject to Iowa Code chapter 476 and to the construction, operation, and maintenance of electric transmission lines by electric utilities as defined in subrule 20.18(4) to the extent provided in Iowa Code chapter 478.

20.18(2) *Purpose and scope.* Reliable electric service is of high importance to the health, safety, and welfare of the citizens of Iowa. The purpose of rule 199—20.18(476,478) is to establish requirements for assessing the reliability of the transmission and distribution systems and facilities that are under the board's jurisdiction. This rule establishes reporting requirements to provide consumers, the board, and electric utilities with methodology for monitoring reliability and ensuring quality of electric

service within an electric utility's operating area. This rule provides definitions and requirements for maintenance of interruption data, retention of records, and report filing.

20.18(3) *General obligations.*

a. Each electric utility shall make reasonable efforts to avoid and prevent interruptions of service. However, when interruptions occur, service shall be reestablished within the shortest time practicable, consistent with safety.

b. The electric utility's electrical transmission and distribution facilities shall be designed, constructed, maintained, and electrically reinforced and supplemented as required to reliably perform the power delivery burden placed upon them in the storm and traffic hazard environment in which they are located.

c. Each electric utility shall carry on an effective preventive maintenance program and shall be capable of emergency repair work on a scale which its storm and traffic damage record indicates as appropriate to its scope of operations and to the physical condition of its transmission and distribution facilities.

d. In appraising the reliability of the electric utility's transmission and distribution system, the board will consider the condition of the physical property and the size, training, supervision, availability, equipment, and mobility of the maintenance forces, all as demonstrated in actual cases of storm and traffic damage to the facilities.

e. Each electric utility shall keep records of interruptions of service on its primary distribution system and shall make an analysis of the records for the purpose of determining steps to be taken to prevent recurrence of such interruptions.

f. Each electric utility shall make reasonable efforts to reduce the risk of future interruptions by taking into account the age, condition, design, and performance of transmission and distribution facilities and providing adequate investment in the maintenance, repair, replacement, and upgrade of facilities and equipment.

g. Any electric utility unable to comply with applicable provisions of rule 199—20.18(476,478) may file a waiver request pursuant to rule 199—1.3(17A,474,476,78GA,HF2206).

20.18(4) *Definitions.* Terms and formulas when used in rule 199—20.18(476,478) are defined as follows:

"Customer" means (1) any person, firm, association, or corporation, (2) any agency of the federal, state, or local government, or (3) any legal entity responsible by law for payment of the electric service from the electric utility which has a separately metered electrical service point for which a bill is rendered. Electrical service point means the point of connection between the electric utility's equipment and the customer's equipment. Each meter equals one customer. Retail customers are end-use customers who purchase and ultimately consume electricity.

"Customer average interruption duration index (CAIDI)" means the average interruption duration for those customers who experience interruptions during the year. It is calculated by dividing the annual sum of all customer interruption durations by the total number of customer interruptions.

$$\text{CAIDI} = \frac{\text{Sum of All Customer Interruption Durations}}{\text{Total Number of Customer Interruptions}}$$

"Distribution system" means that part of the electric system owned or operated by an electric utility and designed to operate at a nominal voltage of 25,000 volts or less.

"Electric utility" means investor-owned electric utilities and electric cooperative corporations and associations owning, controlling, operating, or using transmission and distribution facilities and equipment subject to the board's jurisdiction.

"GIS" means a geospatial information system. This is an information management framework that allows the integration of various data and geospatial information.

"Interrupting device" means a device capable of being reclosed whose purpose is to interrupt faults and restore service or disconnect loads. These devices can be manual, automatic, or motor-operated.

Examples may include transmission breakers, feeder breakers, line reclosers, motor-operated switches, fuses, or other devices.

"Interruption" means a loss of service to one or more customers or other facilities and is the result of one or more component outages. The types of interruption include momentary event, sustained, and scheduled. The following interruption causes shall not be included in the calculation of the reliability indices:

1. Interruptions intentionally initiated pursuant to the provisions of an interruptible service tariff or contract and affecting only those customers taking electric service under such tariff or contract;
2. Interruptions due to nonpayment of a bill;
3. Interruptions due to tampering with service equipment;
4. Interruptions due to denied access to service equipment located on the affected customer's private property;
5. Interruptions due to hazardous conditions located on the affected customer's private property;
6. Interruptions due to a request by the affected customer;
7. Interruptions due to a request by a law enforcement agency, fire department, other governmental agency responsible for public welfare, or any agency or authority responsible for bulk power system security;
8. Interruptions caused by the failure of a customer's equipment; the operation of a customer's equipment in a manner inconsistent with law, an approved tariff, rule, regulation, or an agreement between the customer and the electric utility; or the failure of a customer to take a required action that would have avoided the interruption, such as failing to notify the company of an increase in load when required to do so by a tariff or contract.

"Interruption duration" as used herein in regard to sustained outages means a period of time measured in one-minute increments that starts when an electric utility is notified or becomes aware of an interruption and ends when an electric utility restores electric service. Durations of less than five minutes shall not be reported in sustained outages.

"Interruption, momentary" means single operation of an interrupting device that results in a voltage of zero. For example, two breaker or recloser operations equals two momentary interruptions. A momentary interruption is one in which power is restored automatically.

"Interruption, momentary event" means an interruption of electric service to one or more customers of duration limited to the period required to restore service by an interrupting device. Note: Such switching operations must be completed in a specified time not to exceed five minutes. This definition includes all reclosing operations that occur within five minutes of the first interruption. For example, if a recloser or breaker operates two, three, or four times and then holds, the event shall be considered one momentary event interruption.

"Interruption, scheduled" means an interruption of electric power that results when a transmission or distribution component is deliberately taken out of service at a selected time, usually for the purposes of construction, preventive maintenance, or repair. If it is possible to defer the interruption, the interruption is considered a scheduled interruption.

"Interruption, sustained" means any interruption not classified as a momentary event interruption. It is an interruption of electric service that is not automatically or instantaneously restored, with duration of greater than five minutes.

"Loss of service" means the loss of electrical power, a complete loss of voltage, to one or more customers. This does not include any of the power quality issues such as sags, swells, impulses, or harmonics. Also see definition of "interruption."

"Major event" will be declared whenever extensive physical damage to transmission and distribution facilities has occurred within an electric utility's operating area due to unusually severe and abnormal weather or event and:

1. Wind speed exceeds 90 mph for the affected area, or
2. One-half inch of ice is present and wind speed exceeds 40 mph for the affected area, or
3. Ten percent of the affected area total customer count is incurring a loss of service for a length of time to exceed five hours, or

4. 20,000 customers in a metropolitan area are incurring a loss of service for a length of time to exceed five hours.

"Meter" means, unless otherwise qualified, a device that measures and registers the integral of an electrical quantity with respect to time.

"Metropolitan area" means any community, or group of contiguous communities, with a population of 20,000 individuals or more.

"Momentary average interruption frequency index (MAIFI)" means the average number of momentary electric service interruptions for each customer during the year. It is calculated by dividing the total number of customer momentary interruptions by the total number of customers served.

$$\text{MAIFI} = \frac{\text{Total Number of Customer Momentary Interruptions}}{\text{Total Number of Customers Served}}$$

"OMS" is a computerized outage management system.

"Operating area" means a geographical area defined by the electric utility that is a distinct area for administration, operation, or data collection with respect to the facilities serving, or the service provided within, the geographical area.

"Outage" means the state of a component when it is not available to perform its intended function due to some event directly associated with that component. An outage may or may not cause an interruption of service to customers, depending on system configuration.

"Power quality" means the characteristics of electric power received by the customer, with the exception of sustained interruptions and momentary event interruptions. Characteristics of electric power that detract from its quality include waveform irregularities and voltage variations, either prolonged or transient. Power quality problems shall include, but are not limited to, disturbances such as high or low voltage, voltage spikes and transients, flickers and voltage sags, surges and short-time overvoltages, as well as harmonics and noise.

"Rural circuit" means a circuit not defined as an urban circuit.

"System average interruption duration index (SAIDI)" means the average interruption duration per customer served during the year. It is calculated by dividing the sum of the customer interruption durations by the total number of customers served during the year.

$$\text{SAIDI} = \frac{\text{Sum of All Customer Interruption Durations}}{\text{Total Number of Customers Served}}$$

"System average interruption frequency index (SAIFI)" means the average number of interruptions per customer during the year. It is calculated by dividing the total annual number of customer interruptions by the total number of customers served during the year.

$$\text{SAIFI} = \frac{\text{Total Number of Customer Interruptions}}{\text{Total Number of Customers Served}}$$

"Total number of customers served" means the total number of customers served on the last day of the reporting period.

"Urban circuit" means a circuit where both 75 percent or more of its customers and 75 percent or more of its primary circuit miles are located within a metropolitan area.

20.18(5) *Record-keeping requirements.*

a. Required records for electric utilities with over 50,000 Iowa retail customers.

(1) Each electric utility shall maintain a geospatial information system (GIS) and an outage management system (OMS) sufficient to determine a history of sustained electric service interruptions experienced by each customer. The OMS shall have the ability to access data for each customer in order

to determine a history of electric service interruptions. Data shall be sortable by each of, and in any combination with, the following factors:

1. State jurisdiction;
2. Operating area (if any);
3. Substation;
4. Circuit;
5. Number of interruptions in reporting period; and
6. Number of hours of interruptions in reporting period.

(2) Records on interruptions shall be sufficient to determine the following:

1. Starting date and time the utility became aware of the interruption;
2. Duration of the interruption;
3. Date and time service was restored;
4. Number of customers affected;
5. Description of the cause of the interruption;
6. Operating areas affected;
7. Circuit number(s) of the distribution circuit(s) affected;
8. Service account number or other unique identifier of each customer affected;
9. Address of each affected customer location;
10. Weather conditions at time of interruption;
11. System component(s) involved (e.g., transmission line, substation, overhead primary main, underground primary main, transformer); and
12. Whether the interruption was planned or unplanned.

(3) Each electric utility shall maintain as much information as feasible on momentary interruptions.

(4) Each electric utility shall keep information on cause codes, weather codes, isolating device codes, and equipment failed codes.

1. The minimum interruption cause code set should include: animals, lightning, major event, scheduled, trees, overload, error, supply, equipment, other, unknown, and earthquake.
2. The minimum interruption weather code set should include: wind, lightning, heat, ice/snow, rain, clear day, and tornado/hurricane.
3. The minimum interruption isolating device set should include: breaker, recloser, fuse, sectionalizer, switch, and elbow.
4. The minimum interruption equipment failed code set should include: cable, transformer, conductor, splice, lightning arrester, switches, cross arm, pole, insulator, connector, other, and unknown.
5. Utilities may augment the code sets listed above to enhance tracking.

(5) An electric utility shall retain for seven years the records required by 20.18(5)*"a"*(1) through (4).

(6) Each electric utility shall record the date of installation of major facilities (poles, conductors, cable, and transformers) installed on or after April 1, 2003, and integrate that data into its GIS database.

b. Required records for all other electric utilities.

(1) Each electric utility, other than those providing only wholesale electric service, shall record and maintain sufficient records and reports that will enable it to calculate for the most recent seven-year period the average annual hours of interruption per customer due to causes in each of the following four major categories: power supplier, major storm, scheduled, and all other. Those electric utilities that provide only wholesale electric service shall provide their wholesale customers with the information necessary to allow those customers to ascertain the cause of power supply-related outages.

The category "scheduled" refers to interruptions resulting when a distribution transformer, line, or owned substation is deliberately taken out of service at a selected time for maintenance or other reasons.

The interruptions resulting from either scheduled or unscheduled outages on lines or substations owned by the power supplier are to be accounted for in the "power supplier" category.

The category "major storm" represents service interruptions from conditions that cause many concurrent outages because of snow, ice, or wind loads that exceed design assumptions for the lines.

The "all other" category includes outages primarily resulting from emergency conditions due to equipment breakdown, malfunction, or human error.

(2) When recording interruptions, each electric utility, other than those providing only wholesale electric service, shall use detailed standard codes for interruption analysis recommended by the United States Department of Agriculture, Rural Utilities Service (RUS) Bulletin 161-1, Tables 1 and 2, including the major cause categories of equipment or installation, age or deterioration, weather, birds or animals, member (or public), and unknown. The utility shall also include the subcategories recommended by RUS for each of these major cause categories.

(3) Each electric utility, other than those providing only wholesale electric service, shall also maintain and record data sufficient to enable it to compute systemwide calculated indices for SAIFI-, SAIDI-, and CAIDI-type measurements, once with the data associated with "major storms" and once without.

c. Each electric utility shall make its records of customer interruptions available to the board as needed.

20.18(6) *Notification of major events.* Notification of major events as defined in subrule 20.18(4) shall comply with the requirements of rule 199—20.19(476,478).

20.18(7) *Annual reliability and service quality report for utilities with more than 50,000 Iowa retail customers.* Each electric utility with over 50,000 Iowa retail customers shall submit to the board and consumer advocate on or before May 1 of each year an annual reliability report for the previous calendar year for the Iowa jurisdiction. The report shall include the following information:

a. Description of service area. Urban and rural Iowa service territory customer count, Iowa operating area customer count, if applicable, and major communities served within each operating area.

b. System reliability performance.

(1) An overall assessment of the reliability performance, including the urban and rural SAIFI, SAIDI, and CAIDI reliability indices for the previous calendar year for the Iowa service territory and each defined Iowa operating area, if applicable. This assessment shall include outages at the substation, transmission, and generation levels of the system that directly result in sustained interruptions to customers on the distribution system. These indices shall be calculated twice, once with the data associated with major events and once without. This assessment should contain tabular and graphical presentations of the trend for each index as well as the trends of the major causes of interruptions.

(2) The urban and rural SAIFI, SAIDI, and CAIDI reliability average indices for the previous five calendar years for the Iowa service territory and each defined Iowa operating area, if applicable. The reliability average indices shall include outages at the substation, transmission, and generation levels of the system that directly result in sustained interruptions to customers on the distribution system. Calculation of the five-year average shall start with data from the year covered by the first Annual Reliability Report submittal so that by the fifth Annual Reliability Report submittal a complete five-year average shall be available. These indices shall be calculated twice, once with the data associated with major events and once without.

(3) The MAIFI reliability indices for the previous five calendar years for the Iowa service territory and each defined Iowa operating area for which momentary interruptions are tracked. The first annual report should specify which portions of the system are monitored for momentary interruptions, identify and describe the quality of data used, and update as needed in subsequent reports.

c. Reporting on customer outages.

(1) The reporting electric utility shall provide tables and graphical representations showing, in ascending order, the total number of customers that experienced set numbers of sustained interruptions during the year (i.e., the number of customers who experienced zero interruptions, the number of customers who experienced one interruption, two interruptions, three interruptions, and so on). The utility shall provide this for each of the following:

1. All Iowa customers, excluding major events.
2. All Iowa customers, including major events.

(2) The reporting electric utility shall provide tables and graphical representations showing, in ascending order, the total number of customers that experienced a set range of total annual sustained

interruption duration during the year (i.e., the number of customers who experienced zero hours total duration, the number of customers who experienced greater than 0.0833 but less than 0.5 hour total duration, the number of customers who experienced greater than 0.5 but less than 1.0 hour total duration, and so on, reflecting half-hour increments of duration). The utility shall provide this for each of the following:

1. All Iowa customers, excluding major events.
2. All Iowa customers, including major events.

d. Major event summary. For each major event that occurred in the reporting period, the following information shall be provided:

(1) A description of the area(s) impacted by each major event;
(2) The total number of customers interrupted by each major event;
(3) The total number of customer-minutes interrupted by each major event; and
(4) Updated damage cost estimates to the electric utility's facilities.

e. Information on transmission and distribution facilities.

(1) Total circuit miles of electric distribution line in service at year's end, segregated by voltage level. Reasonable groupings of lines with similar voltage levels, such as but not limited to 12,000- and 13,000-volt three-phase facilities, are acceptable.

(2) Total circuit miles of electric transmission line in service at year's end, segregated by voltage level.

f. Plans and status report.

(1) A plan for service quality improvements, including costs, for the electric utility's transmission and distribution facilities that will ensure quality, safe, and reliable delivery of energy to customers.

1. The plan shall cover not less than the three years following the year in which the annual report was filed. A copy of the electric utility's documents and databases supporting capital investment and maintenance budget amounts required in 20.18(7)*"g"*(1) and 20.18(7)*"h"*(1), respectively, (including but not limited to transmission and distribution facilities, transmission and distribution control and communication facilities, and transmission and distribution planning, maintenance, and reliability-related computer hardware and software) shall be maintained in the utility's principal Iowa business location and shall be available for inspection by the board and office of consumer advocate. The utility's plan may reference said budget documents and databases, instead of duplicating or restating the detail therein. Copies of capital budgeting documents shall be maintained for five years.

2. The plan shall identify reliability challenges and may describe specific projects and projected costs. The filing of the plan shall not be considered as evidence of the prudence of the utility's reliability expenditures.

3. The plan shall provide an estimate of the timing for achievement of the plan's goals.

(2) A progress report on plan implementation. The report shall include identification of significant changes to the prior plan and the reasons for the changes.

g. Capital expenditure information. Reporting of capital expenditure information shall start with data from the year covered by the first Annual Reliability Report submittal so that by the fifth Annual Reliability Report submittal five years of data shall be available in each subsequent annual report.

(1) Each electric utility shall report on an annual basis the total of:

1. Capital investment in the electric utility's Iowa-based transmission and distribution infrastructure approved by its board of directors or other appropriate authority. If any amounts approved by the board of directors are designated for use in a recovery from a major event, those amounts shall be identified in addition to the total.

2. Capital investment expenditures in the electric utility's Iowa-based transmission and distribution infrastructure. If any expenditures were utilized in a recovery from a major event, those amounts shall be identified in addition to the total.

(2) Each electric utility shall report the same capital expenditure data from the past five years in the same fashion as in 20.18(7)*"g"*(1).

h. Maintenance. Reporting of maintenance information shall start with data from the year covered by the first Annual Reliability Report submittal so that by the fifth Annual Reliability Report submittal five years of data shall be available in each subsequent annual report.

(1) Total maintenance budgets and expenditures for distribution, and for transmission, for each operating area, if applicable, and for the electric utility's entire Iowa system for the past five years. If any maintenance budgets and expenditures are designated for use in a recovery from a major event, or were used in a recovery from a major event, respectively, those amounts shall be identified in addition to the totals.

(2) Tree trimming.

1. The budget and expenditures described in 20.18(7)*"h"*(1) shall be stated in such a way that the total annual tree trimming budget expenditures shall be identifiable for each operating area and for the electric utility's entire Iowa system for the past five years.

2. Total annual projected and actual miles of transmission line and of distribution line for which trees were trimmed for the reporting year for each operating area and for the electric utility's entire Iowa system for the reporting year, compared to the past five years. If the utility has utilized, or would prefer to utilize, an alternative method or methods of tracking physical tree trimming progress, it may propose the use of that method or methods to the board in a request for waiver.

3. In the event the utility's actual tree trimming performance, based on how the utility tracks its tree trimming as described in 20.18(7)*"h"*(2)"1," lags behind its planned trimming schedule by more than six months, the utility shall be required to file for the board's approval additional tree trimming status reports on a quarterly basis. Such reports shall describe the steps the utility will take to remediate its tree trimming performance and backlog. The additional quarterly reports shall continue until the utility's backlog has been reduced to zero.

i. The annual reliability report, starting with the reliability report for calendar year 2008, shall include the number of poles inspected, the number rejected, and the number replaced.

20.18(8) *Annual report for all electric utilities not reporting pursuant to 20.18(7).*

a. By July 1, 2003, each electric utility shall adopt and have approved by its board of directors or other governing authority a reliability plan and shall file an informational copy of the plan with the board. The plan shall be updated not less than annually and shall describe the following:

(1) The utility's current reliability programs, including:

1. Tree trimming cycle, including descriptions and explanations of any changes to schedules and procedures reportable in accordance with 199 IAC 25.3(3)*"c"*;

2. Animal contact reduction programs, if applicable;

3. Lightning outage mitigation programs, if applicable; and

4. Other programs the electric utility may identify as reliability-related.

(2) Current ability to track and monitor interruptions.

(3) How the electric utility plans to communicate its plan with customers/consumer owners.

b. By April 1, 2004, and each April 1 thereafter, each electric utility shall prepare for its board of directors or other governing authority a reliability report. A copy of the annual report shall be filed with the board for informational purposes, shall be made publicly available in its entirety to customers/consumer owners, and shall report on at least the following:

(1) Measures of reliability for each of the five previous calendar years, including reliability indices if required in 20.18(5)*"b"*(3). These measures shall start with data from the year covered by the first Annual Reliability Report so that by the fifth Annual Reliability Report submittal reliability measures will be based upon five years of data.

(2) Progress on any reliability programs identified in its plan, but not less than the applicable programs listed in 20.18(8)*"a"*(1).

20.18(9) *Inquiries about electric service reliability.*

a. For electric utilities with over 50,000 Iowa retail customers. A customer may request a report from an electric utility about the service reliability of the circuit supplying the customer's own meter. Within 20 working days of receipt of the request, the electric utility shall supply the report to the customer

at a reasonable cost. The report should identify which interruptions (number and durations) are due to major events.

b. Other utilities are encouraged to adopt similar responses to the extent it is administratively feasible.

[**ARC 8394B**, IAB 12/16/09, effective 1/20/10]

199—20.19(476,478) Notification of outages.

20.19(1) *Notification.* The notification requirements in subrules 20.19(1) and 20.19(2) are for the timely collection of electric outage information that may be useful to emergency management agencies in providing for the welfare of individual Iowa citizens. Each electric utility shall notify the board when it becomes apparent that an outage may result in a loss of service for more than two hours and the outage meets one of the following criteria:

a. For all utilities, loss of service for more than two hours to substantially all of a municipality, including the surrounding area served by the same utility. A utility may use loss of service to 75 percent or more of customers within a municipality, including the surrounding area served by the utility, to meet this criterion;

b. For utilities with 50,000 or more customers, loss of service for more than two hours to 20 percent of the customers in a utility's established zone or loss of service to more than 5,000 customers in a metropolitan area, whichever is less;

c. For utilities with more than 4,000 customers and fewer than 50,000 customers, loss of service for more than two hours to 25 percent or more of the utility's customers;

d. A major event as defined in subrule 20.18(4); or

e. Any other outage considered significant by the electric utility. This includes loss of service for more than two hours to significant public health and safety facilities known to the utility at the time of the notification, even when the outage does not meet the criteria in paragraphs 20.19(1)*"a"* through *"d."*

20.19(2) *Information required.*

a. Notification shall be provided regarding outages that meet the requirements of subrule 20.19(1) by notifying the board duty officer by E-mail at iubdutyofficer@iub.iowa.gov or by telephone at (515)745-2332. Notification shall be made at the earliest possible time after it is determined the event may be reportable and should include the following information, as available:

(1) The general nature or cause of the outage;

(2) The area affected;

(3) The approximate number of customers that have experienced a loss of electric service as a result of the outage;

(4) The time when service is estimated to be restored; and

(5) The name of the utility, the name and telephone number of the person making the report, and the name and telephone number of a contact person knowledgeable about the outage.

The notice should be supplemented as more complete or accurate information is available.

b. The utility shall provide to the board updates of the estimated time when service will be restored to all customers able to receive service or of significant changed circumstances, unless service is restored within one hour of the time initially estimated.

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These rules are intended to implement Iowa Code sections 17A.3, 364.23, 474.5, 476.1, 476.2, 476.6, 476.8, 476.20, 476.54, 476.66, 478.18, and 546.7.

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[Editorial change: IAC Supplement 12/29/10]

[1] Effective date of 20.3(13) *"a," "b,"* (1), (2), (3), (4), and *"c"* delayed 70 days by Administrative Rules Review Committee.

[2] Effective date of 20.4(12), third unnumbered paragraph, delayed seventy days by the Administrative Rules Review Committee.

[3] See IAB, Utilities Division.

[4] Published in Notice portion of IAB 9/10/86; see IAB 10/22/86

[5] Effective date of 20.4(4) delayed until the adjournment of the 1994 Session of the General Assembly pursuant to Iowa Code section 17A.8(9) by the Administrative Rules Review Committee at its meeting held September 15, 1993.

CHAPTER 21
SERVICE SUPPLIED BY WATER UTILITIES
[Prior to 10/8/86, Commerce Commission[250]]

199—21.1(476) Application of rules.

21.1(1) *Application of rules.* The rules apply to any water utility operating within the state of Iowa under the jurisdiction of the Iowa utilities board and are established under Iowa Code chapter 476.

These rules are intended to promote service to the public, provide standards for uniform practices by utilities, and establish a basis for determining the reasonableness of the demands made by the public upon the utilities.

A utility or customer may file for a waiver of these rules in accordance with the provisions of 199—1.3(17A,474,476,78GA,HF2206).

These rules shall not relieve a utility from its duties under the laws of this state.

21.1(2) *Authorization of rules.* Iowa Code chapter 476 provides that the Iowa utilities board shall establish all needful, just, and reasonable rules, not inconsistent with law, to govern the exercise of its powers and duties, the practice and procedure before it, and to govern the form, content, and filing of reports, documents, and other papers necessary to carry out the provisions of this law.

199—21.2(476) Records and reports.

21.2(1) *Location and retention of records.* Unless otherwise specified in this chapter, all records required by these rules shall be kept and preserved in accordance with the applicable provisions of 199—Chapter 18.

21.2(2) *Tariffs.* The utility shall maintain its tariff filing in a current status.

The schedules of rates and rules of all rate-regulated utilities shall be filed with the board.

The form, identification and content of tariffs shall be in accordance with these rules.

a. Form and identification.

(1) The tariff shall be printed, typewritten or otherwise reproduced on 8½ × 11 inch sheets so as to result in a clear and permanent record. The sheets of the tariff should be ruled or spaced to set off a border on the left side suitable for binding.

(2) The title page of every tariff and supplement shall specify the following:

1. The first page shall be the title page, which will show:

Name of Public Utility

Water Tariff

Filed With

The Iowa Utilities Board

2. When a tariff is to be superseded or replaced in its entirety, the replacing tariff shall show on the upper right corner of its title page that it is a revision of a tariff on file and the number being superseded or replaced; for example:

Tariff No. _____
Supersedes Tariff No. _____

3. When a new part of a tariff revises, amends, or eliminates an existing part of a tariff, it shall so state and identify the part revised, amended or eliminated.

4. Any tariff modifications, as defined in "3" above, replacing tariff sheets shall be marked in the right margin with symbols as described below to indicate the place, nature and extent of the change in text:

Symbol	Meaning
(C)	A change in regulation.
(D)	A discontinued or deleted rate, treatment or regulation.
(I)	An increased rate or new treatment resulting in increased rate.
(N)	A new rate, treatment or regulation.
(R)	A reduced rate or new treatment resulting in a reduced rate.
(T)	A change in text but no change in rate, treatment or regulation.

(3) All sheets except the title page shall have, in addition to the above requirements, the issue date.

(4) All sheets except the title page shall have the following form:

(Company Name)	(Part Identification)
Water Tariff	(This sheet identification)
Filed with board	(Canceled sheet identification, if any)
(Content of tariff)	
Issued: (Date)	Effective Date:
	(Proposed Effective Date:)

The issued date is the date the tariff or the amended sheet content was adopted by the utility.

The effective date is to be left blank by the utility and shall be determined by the board. The utility may propose an effective date.

b. Content of tariffs. A tariff filed with the board shall contain:

(1) Table of contents.

(2) Rates, including all rates of utilities subject to rate regulation for service with indication for each rate of the type of water service and the class of customers to which each rate applies. There shall also be shown the prices per unit of service, and the number of units per billing period to which the prices apply, the period of billing, the minimum bill, method of measuring demands and consumptions, including method of calculating or estimating loads or minimums, and any special terms and conditions applicable. There shall be specified any discount for prompt payment or penalty for late payment and the period during which the net amount may be paid, and both shall be in accordance with subrule 21.4(4).

199—21.3(476) General service requirements.

21.3(1) *Disposition of water.*

a. Metered measurement of water. All water sold by a utility shall be on the basis of metered measurement except that the utility may at its option provide flat rate or estimated service for the following:

(1) Temporary service where the water use can be readily estimated.

(2) Public and private fire protection service.

(3) Water used for street sprinkling and sewer flushing.

b. Separate metering for premises. Separate premises shall be separately metered and billed. Submetering shall not be permitted.

21.3(2) *Temporary service.* When the utility renders temporary service to a customer, it may require that the customer bear all the costs of installing and removing the service in excess of any salvage realized.

21.3(3) *Meter requirements.*

a. Meter installation. Each water utility shall adopt a written standard method of meter installation. Copies of standard methods shall be made available upon request. All meters shall be set in place by the utility.

b. Records of meters and associated metering devices. Each utility shall maintain for each meter and associated metering device the following applicable data.

(1) *Meter identification.*

1. Manufacturer.
2. Meter type, catalog number and serial number.
3. Meter capacity, multiplier and constants.
4. Unit registration measures (gallons or cubic feet).
5. Number of moving digits or dials in register.
6. Number of stationary or pointed zeros on register.
7. Pressure rating of the meter.

(2) *Meter location history.*

1. Dates of installation and removal from service.
2. Location of installations.
3. All customer names with readings and read out dates (Remote register readings shall be maintained identical to readings of the meter register).

c. Registration devices for meters. Where a constant or multiplier is necessary to determine the meter reading, it shall be indicated on the face of the meter. Where remote meter reading is used, the customer shall have a readable meter register at the meter.

d. Meter readings.

(1) *Meter reading interval.* Reading of all meters used for determining charges to customers shall be scheduled at least quarterly. An effort shall be made to read meters on corresponding days of each meter reading period. The meter reading date may be advanced or postponed no more than ten days without adjustment of the billing for the period.

The utility may permit the customer to supply the meter readings on a form supplied by the utility, or in the alternative, may permit the customer to supply the meter reading information by telephone, provided a utility representative reads the meter at least once every 24 months and when there is a change of customer.

(2) *Readings and estimates in unusual situations.* When a customer is connected or disconnected, or the regular meter reading date is substantially revised causing a given billing period to be longer or shorter than usual, such bills shall be prorated on a daily basis.

An estimated bill may be rendered in the event that access to meter cannot be gained and a meter reading form left with the customer is not returned in time for the billing operation. Only in unusual cases shall more than three consecutive estimated bills be rendered.

21.3(4) *Filing published meter and service installation rules.* A copy of the utility's current rules, if any, published or furnished by the utility for the use of engineers, architects, plumbing contractors, etc., covering meter and service installation shall be filed with the board.

21.3(5) *Extensions to customers.*

a. Definitions. The following definitions shall apply to the terms used in this rule:

"Advances for construction costs," as used in these subrules, are cash payments or surety bonds or an equivalent surety made to the utility by an applicant for an extension, portions of which may be refunded depending on any subsequent connections made to the extension. Cash payments, surety bonds, or equivalent sureties shall include a grossed-up amount for the income tax effect of such revenue.

"Agreed-upon attachment period," as used in this subrule, means a period of not less than 30 days nor more than one year mutually agreed upon by the utility and the applicant within which the customer will attach. If no time period is mutually agreed upon, the agreed-upon attachment period shall be deemed to be 30 days.

"Contribution in aid of construction," as used in these subrules, means a nonrefundable cash payment covering the costs of an extension that are in excess of utility-funded allowances. Cash

payments shall be grossed-up for the income tax effect of such revenue. The amount of tax shall be reduced by the present value of the tax benefits to be obtained by depreciating the property in determining the tax liability.

"Customer advances for construction records," as used in this subrule, means a separate record established and maintained by the utility, which includes by depositor, the amount of advance for construction provided by the customer, whether the advance is by cash or surety bond or equivalent surety, and if by surety bond, all relevant information concerning the bond or equivalent surety, the amount of refund, if any, to which the depositor is entitled, the amount of refund, if any, which has been made to the customer, the amount unrefunded, and the construction project or work order the extension was installed on.

"Estimated annual revenues," as used in this subrule, shall be calculated based upon the following factors, including, but not limited to: The size of the facility to be used by the customer, the size and type of equipment to be used by the customer, the average annual amount of service required by the equipment, and the average number of hours per day and days per year the equipment will be in use.

"Estimated construction costs," as used in this subrule, shall be calculated using average costs in accordance with good engineering practices and upon the following factors: amount of service required or desired by the customer requesting the extension, size, location and characteristics of the extension, including all appurtenances; and whether or not the ground is frozen or whether other adverse conditions exist. The average cost per foot shall be calculated utilizing the prior calendar year costs, to the extent such cost basis does not exceed the current costs using current construction cost methodologies, resources and material, and working conditions, divided by the total feet of extensions by size of pipe for the prior calendar year. In no event shall estimated construction costs include costs associated with facilities built for the convenience of the utility.

"Extensions" means a distribution main extension.

"Similarly situated customer" is a customer whose annual consumption or service requirements, as defined by estimated annual revenue, is similar to other customers with approximately the same annual consumption or service requirements.

"Utility," as used in these subrules, means a rate-regulated utility.

b. Terms and conditions. The utility shall extend service to new customers under the following terms and conditions:

(1) Plant additions. The utility will provide all water plants at its cost and expense without requiring an advance for construction from customers or developers except in those unusual circumstances where extensive plant additions are required before the customer can be served or where the customer will not attach within the agreed-upon attachment period after completion of construction. In such instances, the utility shall require, no more than 30 days prior to commencement of construction, the customer or developer to advance funds which are subject to refund as additional customers are attached. A contract between the utility and the customer which requires an advance by the customer to make plant additions shall be available for board inspection.

(2) Advances for construction costs for distribution main extensions for customers who will attach within 30 days. Where the customer will attach within 30 days after completion of the distribution main extension, the following shall apply:

1. If the estimated construction cost to provide a distribution main extension is less than or equal to five times the estimated annual revenue calculated on the basis of similarly situated customers, the utility shall finance and make the main extension without requiring an advance for construction.

2. If the estimated construction cost to provide a distribution main extension is greater than five times the estimated annual revenue calculated on the basis of similarly situated customers, the applicant for such an extension shall contract with the utility and deposit an advance for construction equal to the estimated construction cost less five times the estimated annual revenue to be produced by the customer no more than 30 days prior to commencement of construction.

(3) Advances for construction costs for distribution main extensions for customers who will not attach within the agreed-upon attachment period. Where the customer will not attach within the agreed-upon attachment period after completion of the distribution main extension, the applicant for the

extension shall contract with the utility and deposit no more than 30 days prior to the commencement of construction an advance for construction equal to the estimated construction cost.

Advance payments for plant additions or extensions which are subject to refund for a ten-year period may be made by cash, surety bond, or equivalent surety. In the event a surety bond or an equivalent surety is used, the bonded amount shall have added to it a surcharge equal to the annual interest rate paid by the utility on customer bill deposits times the bonded amount. The bond shall be called by the utility at the end of one year or when the earned refunds are equal to the bonded amount, less the surcharge, whichever occurs first. If, upon termination of the surety bond, there are sufficient earned refunds to offset the amount of the surety bond, less the surcharge, the depositors shall provide the utility the amount of the surcharge. If, upon termination of the surety bond, there are not sufficient earned refunds to offset the full amount of the surety bond, less the surcharge, the depositors shall provide the utility a cash deposit equal to the amount of the surety bond, less refunds accumulated during the bonded period, plus the surcharge, or the depositor may pay the interest on the previous year's bond and rebond the balance due to the utility for a second or third one-year period. Upon receipt of such cash deposit, the utility shall release the surety bond. The cash deposit, less the surcharge, shall be subject to refund by the utility for the remainder of the ten-year period.

c. Refunds. The utility shall refund to the depositor for a period of ten years from the date of the original advance, a pro-rata share for each service attachment to the distribution main extension. The pro-rata refund shall be computed in the following manner:

(1) If the combined total of three times estimated annual revenue for the depositor and each customer who has attached to the distribution main extension exceeds the total estimated construction cost to provide the extension, the entire amount of the advance provided by the depositor shall be refunded to the depositor.

(2) If the combined total of three times estimated annual revenue for the depositor and each customer who has attached to the distribution main extension is less than the total estimated construction cost to provide the extension, the amount to be refunded to the depositor shall equal three times estimated annual revenue of the customer attaching to the extension.

(3) In no event shall the total amount to be refunded to a depositor exceed the amount of the advance for construction made by the depositor. Any amounts subject to refund shall be paid by the utility without interest. At the expiration of the above-described ten-year period, the customer advance for construction record shall be closed and the remaining balance shall be credited to the respective plant account.

d. Extensions not required. Utilities shall not be required to make extensions as described in this rule, unless the extension shall be of a permanent nature.

e. Extensions permitted. This rule shall not be construed as prohibiting any utility from making a contract with a customer in a different manner, if the contract provides a more favorable method of extension to the customer, so long as no discrimination is practiced among customers or depositors.

This rule shall not be construed as prohibiting an individual, partnership, or company from constructing its own extension. An extension constructed by a nonutility entity must meet at a minimum the applicable portions of the standards in 21.5(1) and 21.5(2) and such other reasonable standards as the utility may employ in constructing extensions, so long as the standards do not mandate a particular supplier. All connections to the utility-owned equipment or facilities shall be made by the utility at the applicant's expense. At the time of attachment to the utility-owned equipment or facilities, the applicant shall transfer ownership of the extension to the utility and the utility shall book the original cost of construction of the extension as an advance for construction, and refunds shall be made to the applicant in accordance with 21.3(5)*"c."* The utility shall be responsible for the operation and maintenance of the extension after attachment.

If the utility requires the applicant to construct the extension to meet service requirements greater than those necessary to serve the applicant's service needs, the utility shall reimburse the applicant for the difference in cost between the extension specifications required by the utility and the extension specifications necessary to meet the applicant's service needs.

21.3(6) *Service connections.* In urban areas with well-defined streets, the utility shall control (supervise the installation and maintenance of) that portion of the service pipe from its main to and

including the customer's meter. A curb stop shall be installed at a convenient place between the property line and the curb. All services shall include a curb stop and curb box or meter vault. In installations where meters are installed in meter vaults incorporating a built-in valve, and are installed between property line and curb, no separate curb stop and curb box is required.

21.3(7) *Location of meters.* Meters may be installed outside or inside as mutually agreed upon by the customer and utility.

a. Outside. Meters installed out-of-doors shall be readily accessible for maintenance and reading and so far as practicable the location should be mutually acceptable to the customer and the utility. The meter shall be installed so as to be unaffected by climatic conditions and reasonably secure from injury.

b. Inside. Meters installed inside the customer's building shall be located as near as possible to the point where the service pipe enters the building and at a point reasonably secure from injury and readily accessible for reading and testing. In cases of multiple buildings, such as two-family dwellings or apartment buildings, the meter(s) shall be located within the premises served or in a common location accessible to the customers and the utility.

199—21.4(476) Customer relations.

21.4(1) *Customer information.* Each utility shall:

a. Post a notice in a conspicuous place in each office of the utility where applications for service are received, informing the public that copies of the rate schedules and rules relating to the service of the utility are available for public inspection.

b. Maintain up-to-date maps, plans, or records of its entire water system.

c. Upon request, assist the customer or proposed customers in selecting the most economic rate schedule available for the proposed type of service.

d. Upon request, inform its customers as to the method of reading meters and the method of computing the customer's bill.

e. Notify customers affected by a change in rates or rate classification as directed in the board rules of practice and procedures.

f. Inquiries for information or complaints to a utility shall be resolved promptly and courteously. Employees who receive customer telephone calls and office visits shall be qualified and trained in screening and resolving complaints, to avoid a preliminary recitation of the entire complaint to employees without ability and authority to act. The employee shall provide identification to the customer which will enable the customer to reach that employee again if needed.

Each utility shall notify its customers, by bill insert or notice on the bill form, of the address and telephone number where a utility representative qualified to assist in resolving the complaint can be reached. The bill insert or notice shall also include the following statement: "If (utility name) does not resolve your complaint, you may request assistance from the Iowa Utilities Board by calling 1-877-565-4450, by writing 1375 E. Court Avenue, Room 69, Des Moines, Iowa 50319-0069, or by E-mail to customer@iub.iowa.gov."

The bill insert or notice on the bill will be provided no less than annually. Any utility which does not use the standard form contained herein shall file its proposed form in its tariff for approval. A utility which bills by postcard may place an advertisement in a local newspaper of general circulation or a customer newsletter instead of a mailing. The advertisement must be of a type size that is easily legible and conspicuous and must contain the information set forth above.

21.4(2) *Customer deposits.*

a. Deposit required. Each utility may require from any customer or prospective customer a deposit intended to guarantee payment of bills for service.

b. Amount of deposit. The total deposit shall not be less than $5 nor more in amount than the maximum estimated charge for service for 90 days or as may reasonably be required by the utility in cases involving service for short periods or special occasions.

c. New or additional deposit. A new or additional deposit may be required from a customer when a deposit has been refunded or is found to be inadequate. Written notice shall be mailed advising the customer of any new or additional deposit requirement. The customer shall have no less than 12 days

from the date of mailing to comply. No written notice is required to be given of a deposit required as a prerequisite for commencing initial service.

d. Customer's deposit receipt. The utility shall issue a receipt of deposit to each customer from whom a deposit is received.

e. Interest on customer deposits. Interest shall be paid by the rate-regulated utility to each customer required to make a deposit. On or after April 21, 1994, rate-regulated utilities shall compute interest on customer deposits at 7.5 percent per annum, compounded annually. Interest for prior periods shall be computed at the rate specified by the rule in effect for the period in question. Interest shall be paid for the period beginning with the date of deposit to the date of refund or to the date that the deposit is applied to the customer's account, or to the date the customer's bill becomes permanently delinquent. The date of refund is that date on which the refund or the notice of deposit refund is forwarded to the customer's last-known address. The date a customer's bill becomes permanently delinquent is the most recent date the account is treated as uncollectible.

f. Deposit refund. The deposit shall be refunded after 12 consecutive months of prompt payment, unless the utility has evidence to indicate that the deposit is necessary to ensure payment of bills for service. In any event, the deposit shall be refunded upon termination of the customer's service.

g. Unclaimed deposits. The utility shall make a reasonable effort to return each unclaimed deposit and accrued interest after the termination of the services for which the deposit was made. The utility shall maintain a record of deposit information for at least two years or until such time as the deposit, together with accrued interest escheats to the state pursuant to Iowa Code section 556.4 at which time the record and deposit, together with accrued interest, less any lawful deductions, shall be sent to the state treasurer pursuant to Iowa Code section 556.11.

21.4(3) *Customer bill forms.* The utility shall bill each customer as promptly as possible following the reading of the customer's meter. Each bill, including the customer's receipt, shall show:

a. The date and the reading of the meter at the beginning and at the end of the period or the period for which the bill is rendered.

b. The number of units metered when applicable.

c. Identification of the applicable rate schedule.

d. The gross and net amount of the bill.

e. The delayed payment charge and the latest date on which the bill may be paid without incurring a penalty.

f. A distinct marking to identify an estimated bill.

21.4(4) *Bill payment terms.* The bill shall be considered rendered to the customer when deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the bill shall be considered rendered when delivered to the last-known address of the party responsible for payment. There shall be not less than 20 days between the rendering of a bill and the date by which the account becomes delinquent.

A rate-regulated utility's late payment charge shall not exceed 1.5 percent per month of the past due amount.

Each account shall be granted not less than one complete forgiveness of a late payment charge each calendar year. The utility's rules shall be definitive that on one monthly bill in each period of eligibility, the utility will accept the net amount of such bill as full payment for such month after expiration of the net payment period.

The company rules shall state how the customer is notified the eligibility has been used.

21.4(5) *Customer records.* The utility shall retain customer billing records for the length of time necessary to permit the utility to comply with 21.4(6), but not less than three years.

21.4(6) *Adjustment of bills.* Bills which are incorrect due to meter or billing errors are to be adjusted as follows:

a. Fast meters. Whenever a meter in service is tested and found to have overregistered more than 2 percent, the utility shall adjust the customer's bill for the excess amount paid. The estimated amount of overcharge is to be based on the period the error first developed or occurred. If that period cannot be definitely determined, it will be assumed that the overregistration existed for a period equal to one-half

the time since the meter was last tested, or one-half the time since the meter was installed unless otherwise ordered by the board. If the recalculated bill indicates that more than $5 is due an existing customer, the full amount of the calculated difference between the amount paid and the recalculated amount shall be refunded to the customer. If a refund is due a person no longer a customer of the utility, a notice shall be mailed to the last-known address.

b. Nonregistering meters. Whenever a meter in service is found not to register, the utility may render an estimated bill.

c. Slow meters. Whenever a meter is found to be more than 2 percent slow, the utility may bill the customer for the amount the test indicates the customer has been undercharged for the period of inaccuracy, or a period as estimated in 21.4(6)*"a"* unless otherwise ordered by the board.

d. Overcharges. When a customer has been overcharged as a result of incorrect reading of the meter, incorrect application of the rate schedule, incorrect connection of the metering installation, or other similar reasons, the amount of the overcharge shall be adjusted, refunded or credited to the customer. The time period for which the utility is required to adjust, refund or credit the customer's bill shall not exceed five years unless otherwise ordered by the board.

e. Undercharges. When a customer has been undercharged as a result of incorrect reading of the meter, incorrect application of the rate schedule, incorrect connection of the metering installation, or other similar reasons, the tariff may provide for billing the amount of the undercharge to the customer. The time period for which the utility may adjust for the undercharge need not exceed five years unless otherwise ordered by the board. The maximum bill shall not exceed the billing for like charges (e.g., usage-based, fixed or service charges) in the 12 months preceding discovery of the error unless otherwise ordered by the board.

21.4(7) *Refusal or disconnection of service.* Service may be refused or discontinued only for the reasons listed below. Unless otherwise stated, the customer shall be permitted at least 12 days, excluding Sundays and legal holidays, following mailing of notice of disconnect in which to take necessary action before service is discontinued.

a. Without notice in the event of an emergency.

b. Without notice in the event of tampering with the equipment furnished and owned by the utility or obtaining water by fraudulent means.

c. For violation of or noncompliance with the utility's rules on file with the board.

d. For failure of the customer to permit the utility reasonable access to its equipment.

e. For nonpayment of bill provided that the utility has: (1) Made a reasonable attempt to effect collection; (2) Given the customer written notice that the customer has at least 12 days, excluding Sundays and legal holidays, in which to make settlement of the account. In the event there is dispute concerning a bill for water service, the utility may require the customer to pay a sum of money equal to the amount of the undisputed portion of the bill pending settlement and thereby avoid discontinuance of service for nonpayment of the disputed bill for up to 45 days after the rendering of the bill. The 45 days shall be extended by up to 60 days if requested of the utility by the board in the event the customer files a written complaint with the board.

f. When a prospective customer is refused service, the utility shall notify the prospective customer promptly of the reason for the refusal to serve and of the applicant's right to appeal the utility's decision to the board.

21.4(8) *Reconnection and charges.* In all cases of discontinuance of service where the cause of discontinuance has been corrected, the utility shall promptly restore service to the customer. The utility may make a reasonable charge applied uniformly for reconnection of service.

21.4(9) *Insufficient reasons for denying service.* The following shall not constitute sufficient cause for refusal of service to a present or prospective customer:

a. Nonpayment for service by someone who is no longer an occupant of the premises to be served, except in cases of immediate family occupation or cohabitation of adults at the premises.

b. Failure to pay the bill of another customer as guarantor thereof.

c. Failure to pay for a different type or class of public utility service.

21.4(10) *Customer complaints.* A "complaint" shall mean any objection to the charge, facilities, or quality of service of a utility.

a. Each utility shall investigate promptly and thoroughly and keep a record of all complaints received from its customers that will enable it to review its procedures and actions. The record shall show the name and address of the complainant, the date and nature of the complaint, and its disposition and the date resolved.

b. All complaints caused by a major service interruption shall be summarized in a single report.

c. A record of the original complaint shall be kept for a period of three years after final settlement of the complaint.

[Editorial change: IAC Supplement 12/29/10]

199—21.5(476) Engineering practice.

21.5(1) *Requirement of good engineering practice.* The design and construction of the utility's water plant shall conform to good standard engineering practice.

21.5(2) *Inspection of water plant.* Each utility shall adopt and follow a program of inspection of its water plant in order to determine the necessity for replacement and repair. The frequency of the various inspections shall be based on the utility's experience and accepted good practice.

199—21.6(476) Meter testing.

21.6(1) *Periodic and routine tests.* Each utility shall adopt schedules approved by the board for periodic and routine tests and repair of its meters.

21.6(2) *Meter test facilities and equipment.* Each utility furnishing metered water service shall provide the necessary standard facilities, instruments and other equipment for testing its meters, or mail for test of its meters by another utility or agency equipped to test meters subject to approval by the board.

21.6(3) *Accuracy requirements.* All meters used for measuring quantity of water delivered to a customer shall be in good mechanical condition. All meters shall be accurate to the following standards:

a. Test flow limits. For determination of minimum test flow and normal test flow limits, the company will use as a guide the appropriate standard specifications of the American Water Works Association for the various types of meters.

b. Accuracy limits. A meter shall not be placed in service if it registers less than 95 percent of the water passed through it at the minimum test flow, or overregisters or underregisters more than 1.5 percent at the intermediate or maximum limit.

21.6(4) *Initial test and storage of meters.* Every water meter shall be tested prior to its installation either by the manufacturer, the utility, or an organization equipped for meter testing.

If a meter is not stored as recommended by the manufacturer, the meter shall be tested immediately before installation.

21.6(5) *As found tests.* To determine the average meter error in accordance with these rules for periodic or complaint tests, meters shall be tested in the condition as found in the customer's service. Tests shall be made at intermediate and maximum rates of flow and the meter error shall be the algebraic average of the errors of the two tests.

21.6(6) *Request tests.* A utility shall test any water meter upon written request of a customer. The utility will not be required to perform request tests more than once each 18 months. The customer shall be given the opportunity to be present at the request tests.

21.6(7) *Board-ordered tests.* The board shall order tests of meters as follows:

a. Application. Upon written application to the board by a customer or a utility, a test shall be made of the customer's meter as soon as practicable.

b. Guarantee. The application shall be sent by certified or registered mail and accompanied by a certified check or money order made payable to the utility in the amount indicated below:

(1) Capacity of 80 gallons per minute or less	$24
(2) Capacity over 80 gallons, up to 120 gallons per minute	$26
(3) Capacity of over 120 gallons per minute	$30

c. Conduct of test. On receipt of a request from a customer, the board shall forward the deposit to the utility and notify the utility of the requirement for the test. The utility shall not knowingly remove or adjust the meter until tested. The utility shall furnish all instruments, load devices and other facilities necessary for the test and shall perform the test and shall furnish verification of the accuracy of test instruments used.

d. Test results. If the tested meter is found to overregister to an extent requiring a refund under the provisions of 21.4(6)*"a,"* the amount paid to the utility shall be returned to the customer by the utility.

e. Notification. The utility shall notify the customer in advance of the date and time of the board-ordered test.

f. Utility report. The utility shall make a written report of the results of test which shall be sent to the customer and to the board.

21.6(8) *Sealing of meters.* Upon completion of adjustment and test of any water meter the utility shall place a suitable register seal on the meter in a manner that adjustment or registration of the meter cannot be changed without breaking the seal.

21.6(9) *Record of meter tests.* Meter test records shall include:

a. The date and reason for the test.

b. The meter reading prior to any test.

c. The accuracy as found at each of the flow rates required by 21.6(3)*"a."*

d. The accuracy as left at each of the flow rates required by 21.6(3)*"a."*

e. Statement of any repairs.

f. If the meter test is made using a standard meter, the utility shall retain all data taken at the time of the test sufficient to permit the convenient checking of the test method, calculations, and traceability to the National Bureau of Standards' volumetric standardization.

The test records of each meter shall be retained for two consecutive periodic tests or at least for two years. A record of the test made at the time of the meter's retirement, if any, shall be retained for a minimum of three years.

199—21.7(476) Standards of quality of service.

21.7(1) *Pressures.* Under normal condition of water usage the pressure (pound per square inch gauge) at a customer's service line shall be not less than 25 PSIG and not more than 125 PSIG.

At regular intervals, a utility shall make a survey of pressures in its water system. The survey shall be of sufficient magnitude to indicate the quality of service being rendered at representative points on its system. Survey should be conducted during periods of high usage at or near the maximum usage during the year. The pressure charts for these surveys shall show the date and time of beginning and end of the test, and the test location. Records of these pressure surveys shall be maintained at the utility's principal office in the state and made available to the board upon request.

21.7(2) *Interruption of supply.*

a. A utility shall make a reasonable effort to prevent interruptions of service. When an emergency interruption occurs the utility shall reestablish service with the shortest possible delay consistent with the safety to its customers and the general public. If an emergency interruption affects fire protection service, the utility shall immediately notify the fire chief or other responsible local official.

b. When a utility finds it necessary to schedule an interruption of service, it shall make a reasonable effort to notify all customers to be affected by the interruption. The notice shall include the time and anticipated duration of the interruption. Interruptions should be scheduled at hours which create the least inconvenience to the customer.

c. A utility shall retain records of interruptions for a period of at least five years.

21.7(3) *Supply shortage.* The utility shall attempt to furnish a continuous and adequate supply of water to its customers and to avoid any shortage or interruption of water delivery.

a. If a utility finds that it is necessary to restrict the use of water, it shall notify its customers, and give the board notice, before the restriction becomes effective. The notification shall specify:

(1) The reason for the restriction.

(2) The nature and extent of the restriction.

(3) The effective date of the restriction.

(4) The probable date of termination of the restriction.

b. During the times of threatened or actual water shortage, the utility shall equitably apportion its available water supply among its customers.

199—21.8(476) Applications for water costs for fire protection services.

21.8(1) *Definition.* For purposes of these rules, "water costs for fire protection service" shall be defined as all or a part of the utility's costs of fire hydrants and other improvements, maintenance, and operations for the purpose of providing adequate water production, storage, and distribution for public fire protection, as reflected in the utility's current tariff for public fire protection water service.

21.8(2) *Utility requirements.* A rate-regulated utility which provides public fire protection water service to a city preparing an application pursuant to subrule 21.8(3) shall provide the city all necessary information and affidavits to enable the city to meet its application filing requirements.

21.8(3) *Application contents.* Any city filing an application with the board requesting inclusion of all or a part of the water costs for fire protection service in a rate-regulated utility's rates or charges to customers covered by the city's fire protection service shall submit, at the time the application is filed, the following information with supporting testimony:

a. A statement showing (1) the proposed method of allocating costs to affected customers, and (2) both the proposed per-customer rate increase and the average percentage increase by customer class, based on the utility's current tariff, if the costs for fire protection water service are included in rates charged to affected customers;

b. Copies of all bills rendered to the city by the utility for public fire protection water service during the preceding 24-month period;

c. The current number of utility customers served within the city's corporate limits, by customer class, with an affidavit from the utility verifying the information;

d. A map illustrating both (1) the city's corporate limits, and (2) the portion of the utility's customer service area within the city's corporate limits, with an affidavit from the utility verifying the customer service area;

e. An affidavit from the utility showing that the notice required by Iowa Code section 476.6(18)*"c"* and subrule 21.8(4) has been provided and paid for by the applicant and mailed by the utility to all affected customers.

21.8(4) *Customer notification.*

a. Prior approval. The city shall submit to the board for its approval, not less than 30 days before providing notification to affected customers, ten copies of the proposed notice.

b. Required content of notification. The notice shall advise affected customers of the proposed increase in rates and charges, the proposed effective date of the increase, and the percentage increase by customer class. It shall advise customers that the city is requesting the increase and that they have a right to file with the board a written objection to the proposed increase and to request a public hearing. It shall also include a written explanation of the reason for the increase.

c. Notice of deficiencies. Within 30 days of the filing of the proposed notice, the city shall be notified of either the approval of the notice or of any deficiencies in the notice and the corrective measures required for approval.

d. Distribution. The city shall provide to the utility, for mailing, a sufficient number of copies of the approved notice. The city shall direct the utility either to (1) include the notice with the utility's next regularly scheduled mailing to the affected customers; or (2) make a separate mailing of the notice to affected customers within 30 days of receiving from the city the requisite number of copies of the notice. The city shall pay all expenses incurred by the utility in providing notice to affected customers. The utility may require payment prior to the mailing.

e. Delivery. The written notice to affected customers shall be mailed or delivered by the utility not more than 90 days before the application is filed and no later than the date the application is filed.

21.8(5) *Procedure.*

a. Service of application. The applicant shall file an original plus ten copies of the application with the executive secretary's office, serve two copies of the application on the public utility and serve two copies on the consumer advocate division of the Iowa department of justice.

b. Docketing. Within 30 days of the filing of the application, the board shall either approve the application or docket the case as a formal proceeding and establish a procedural schedule.

c. Rules. If the case is docketed as a formal proceeding, the rules in 199—Chapter 7, if not inconsistent, shall apply.

d. Decision. The board shall render its decision within six months of the date of the application. If the application is approved, the board shall order the rate-regulated utility providing the water service to the city to file tariffs implementing the board's decision. The utility shall include annually a bill insert explaining to customers that they are being charged for water-related fire protection costs. The city shall pay all costs incurred by the utility to file and implement the required tariff.

199—21.9(476) Incident reports. A regulated public water utility shall notify the board when it notifies the Iowa department of natural resources or the local county health department about an incident involving: (1) an occurrence of waterborne emergency (e.g., treatment process malfunction, chemical/biological spill in the water supply, contamination event in the distribution system, emergency that has the potential for drinking water contamination); (2) a boil water advisory and contamination event; or (3) a low-pressure event (less than 20 psi) affecting a widespread area of the system. Notification shall be made to the board by calling the board duty officer at (515)745-2332. The caller shall leave a call-back number for a person knowledgeable about the incident. The utility shall report to the board when the incident has ended and normal water service has been restored.

These rules are intended to implement Iowa Code sections 17A.3, 474.5, 476.1, 476.2, 476.6(18), 476.8, and 546.7.

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[1] Effective date of 21.3(12)*"a," "b"*(1) and (3), and *"e"* delayed 70 days by the Administrative Rules Review Committee.

[2] Effective date of 21.4(2)"e" delayed until the adjournment of the 1994 Session of the General Assembly pursuant to Iowa Code section 17A.8(9) by the Administrative Rules Review Committee at its meeting held September 15, 1993.

CHAPTER 22
RATES CHARGED AND SERVICE SUPPLIED BY TELEPHONE UTILITIES
[Prior to 10/8/86, Commerce Commission[250]]

199—22.1(476) General information.

22.1(1) *Application and purpose of rules.* The rules shall apply to any telephone utility operating within the state of Iowa subject to Iowa Code chapter 476, and shall supersede all conflicting rules of any telephone utility which were in force and effect prior to the adoption of their superseding rules. Unless otherwise indicated, "telephone utility" or "utility" shall mean both local exchange utility and alternative operator services company. These rules shall be construed in a manner consistent with their intent:

a. To allow fair competition in the public interest while ensuring the availability of safe and adequate communications service to the public.

b. To provide uniform, reasonable standards for communications service provided by telephone utilities.

c. To ensure that the provision of service of local exchange utilities and the charges of alternative operator services companies for communications service, and regulated services rendered in connection therewith, will be reasonable and just.

d. To ensure that no telephone utility shall unreasonably discriminate among different customers or service categories.

22.1(2) *Waiver and modification.* If unreasonable hardship to a utility or to a customer or user results from the application of any rule herein prescribed, application may be made to the board for the modification of the rule or for temporary or permanent exemption from its requirements.

The adoption of these rules shall in no way preclude the board from altering or amending them, pursuant to statute, or from making such modifications with respect to their application as may be found necessary to meet exceptional conditions.

22.1(3) *Definitions.* For the administration and interpretation of these rules, the following words and terms shall have the meaning indicated below:

"Active account" refers to a customer who is currently receiving telephone service, or one whose service has been temporarily disconnected (vacation, nonpayment, storm damage, etc.).

"Adjacent exchange service" is local telephone service, including extended area service, provided to a customer via direct facility connection to an exchange contiguous to the exchange in which the customer is located.

"Average busy-season, busy-hour traffic" means the average traffic volume for the busy-season, busy-hours.

"Base rate area" means the developed portion or portions within each exchange service area as set forth in the telephone utility's tariffs, maps or descriptions.

"Board" means the Iowa utilities board.

"Business service" means the service furnished to customers where the use is substantially of a business, professional, institutional, or occupational nature, rather than a social and domestic nature.

"Busy-hour" means the two consecutive half hours during which the greatest volume of traffic is handled in the office.

"Busy-season" means that period of the year during which the greatest volume of traffic is handled in the office.

"Calls" means telephone messages attempted by customers or users.

"Central office" means a unit in a telephone system which provides service to the general public, having the necessary equipment and operating arrangements for terminating and interconnecting customer lines and trunks or trunks only. There may be more than one central office in a building.

"Central office access line" means a circuit extending from the central office equipment to the demarcation point.

"Channel" means an electrical path suitable for the transmission of communications.

"Check of service" or *"service check"* means an examination, test or other method utilized to determine the condition of customer-provided terminal equipment and existing or new inside station wiring.

"Class of service" means the various categories of service generally available to customers, such as business or residence.

"Competitive Local Exchange Carrier" or *"CLEC"* means a utility, other than an incumbent local exchange carrier, that provides local exchange service pursuant to an authorized certificate of public convenience and necessity.

"Customer" means any person, firm, association, corporation, agency of the federal, state or local government, or legal entity responsible by law for payment for communication service from the telephone utility.

"Customer provision" means customer purchase or lease of terminal equipment or inside station wiring from the telephone company or from any other supplier.

"Delinquent or delinquency" means an account for which a bill or payment agreement for regulated services or equipment has not been paid in full on or before the last day for timely payment.

"Demarcation point" means the point of connection provided and maintained by the telephone utility to which inside station wiring becomes dedicated to an individual building or facility. For an individual dwelling, this point of connection will generally be immediately adjacent to, or within 12 inches of, the protector or the dwelling side of the protector. The drop and block, including the protector, will continue to be provided by and remain the property of the telephone utility. In the instance where a physical protector does not exist at the point of cable entrance into the building or facility, the demarcation point is defined as the entrance point of the cable into the building or facility.

"Disconnect" means the disabling of circuitry preventing both outgoing and incoming communications.

"Due date" means the last day for payment without unpaid amounts being subject to a late payment charge or additional collection efforts.

"Exchange" means a unit established by a telephone utility for the administration of communication services.

"Exchange service" means communication service furnished by means of exchange plant and facilities.

"Exchange service area" or *"exchange area"* means the general area in which the telephone utility holds itself out to furnish exchange telephone service.

"Extended area service" means telephone service, furnished at flat rates, between end user customers located within an exchange area and all of the end user customers of an additional exchange area. Extended area service is only for calls both originating and terminating within the defined extended area.

"Foreign exchange service" means exchange service furnished a customer from an exchange other than the exchange regularly serving the area in which the customer is located.

"Former account" refers to a customer whose service has been permanently disconnected, and the final bill either has been paid or has been written off to the reserve for uncollectible accounts.

"Held order for primary service" means an application for establishment of primary service to a local exchange utility using its existing facilities to provide service not filled within five business days of the customer-requested date, or within 15 business days of the customer-requested date, where no facilities are available. During the period a local exchange utility provides equivalent alternative service, the customer's order for primary service shall not be considered a held order.

"Held order for secondary service" means an application for establishment of secondary service to a local exchange utility using its facilities to provide service not filled within 30 business days or the customer-requested date, whichever is later.

"High-volume access service (HVAS)" is any service that results in an increase in total billings for intrastate exchange access for a local exchange utility in excess of 100 percent in less than six months. By way of illustration and not limitation, HVAS typically results in significant increases in interexchange call volumes and can include chat lines, conference bridges, call center operations, help desk provisioning,

or similar operations. These services may be advertised to consumers as being free or for the cost of a long-distance call. The call service operators often provide marketing activities for HVAS in exchange for direct payments, revenue sharing, concessions, or commissions from local service providers.

"Inactive account" refers to a customer whose service has been permanently disconnected and whose account has not been settled either by payment or refund.

"Incumbent Local Exchange Carrier" or *"ILEC"* means a utility, or successor to such utility, that was the historical provider of local exchange service pursuant to an authorized certificate of public convenience and necessity within a specific geographic area described in maps approved by the board as of September 30, 1992.

"Interexchange service" is the provision of intrastate telecommunications services and facilities between local exchanges, and does not include EAS.

"Interexchange utility" means a utility, a resale carrier or other entity that provides intrastate telecommunications services and facilities between exchanges within Iowa, without regard to how such traffic is carried. A local exchange utility that provides exchange service may also be considered an interexchange utility.

"InterLATA toll service" means toll service that originates and terminates between local access transport areas.

"IntraLATA toll service" means toll service that originates and terminates within the same local access transport area.

"Intrastate access services" are services of telephone utilities which provide the capability to deliver intrastate telecommunications services which originate from end-users to interexchange utilities and the capability to deliver intrastate telecommunications services from interexchange utilities to end-users.

"Local exchange service" means telephone service furnished between customers or users located within an exchange area.

"Local exchange utility" means a telephone utility that provides local exchange service under tariff filed with the board. The utility may also provide other services and facilities such as access services.

"Message" means a completed telephone call by a customer or user.

"Message rate service" means service for which the customer charges are based on message units depending in part upon the number of originated local or extended area service messages.

"Outside plant" means the telephone equipment and facilities installed on, along, or under streets, alleys, highways, and private rights-of-way between customer locations, central offices or the central office and customer location.

"Percentage of fill" means the ratio of circuits and equipment in use to the total available multiplied by 100.

"Premises" means the space occupied by an individual customer in a building, in adjoining buildings occupied entirely by that customer, or on contiguous property occupied by the customer separated only by a public thoroughfare, a railroad right-of-way, or a natural barrier.

"Primary service" means the initial access to the public switched network.

"Protector" means a utility-owned electrical device located in the central office, at a customer's premises or anywhere along any telephone facilities which protects both the telephone utility's and the customer's property and facilities from over-voltage and over-current by shunting such excessive voltage and currents to ground.

"Rate zone" means an area other than base rate area within an exchange service area where service generally is furnished at uniform rates without mileage charges.

"Rates" shall mean amounts billed to customers for local exchange service and alternative operator services.

"Rural service" means service in an exchange area outside of a base rate area or generally outside a special rate area.

"Secondary service" means services or facilities not classified as primary service.

"Special rate area" means an area within an exchange where service generally is furnished at uniform rates. Usually this comprises a developed area outside of the base rate area which is also known as a "locality rate area" and separated by some distance from the base rate area.

"Suspend" means temporary disconnection or impairment of service which shall disable either outgoing or incoming communications, or both.

"Switching service" means switching performed for service lines.

"Tariff" means the entire body of rates, classifications, rules, procedures, policies, etc., adopted and filed with the board by a telephone utility, including an alternative operator services company, in fulfilling its role of furnishing communications services.

"Telephone station" means the telephone instrument connected to the network.

"Telephone utility" or *"utility"* means any person, partnership, business association, or corporation, domestic or foreign, owning or operating any facilities for furnishing communications service to the public for compensation.

"Terminal equipment" means all telephone instruments, including pay telephone equipment, the common equipment of large and small key and PBX systems and other devices and apparatus, and associated wirings, which are intended to be connected electrically, acoustically or inductively to the telecommunication system of the telephone utility.

"Timely payment" is a payment on a customer's account made on or before the due date shown: (1) On a current bill for rates and charges, or (2) by an agreement between the customer and a utility for a series of partial payments to settle a delinquent account.

"Toll connecting trunks" means a general classification of trunks carrying toll traffic and ordinarily extending between a local office and a toll office.

"Toll message" means a message made between different exchange areas for which a charge is made, excluding message rate service charges.

"Toll rate" means the charge prescribed for toll messages, usually based upon the duration of the message, the distance between the exchanges, the day and time of the message and the degree of operator assistance.

"Traffic" means telephone call volume, based on number and duration of calls.

"Traffic grade of service" means the decimal fraction representing the probability of a call being blocked by an all-trunks-busy condition during the average busy-season, busy-hour.

"Trouble report" means any call or written statement from a customer or user of telephone service relating to a physical defect or to difficulty or dissatisfaction with the operation of telephone facilities.

22.1(4) *Abbreviations.*

AOS—Alternative Operator Services

EAS—Extended Area Service

PBX—Private Branch Exchange

22.1(5) *Basic utility obligations.* Each telephone utility shall provide telephone service to the public in its service area in accordance with its rules and tariffs on file with the board. Such service shall normally meet or exceed the standards set forth in these rules governing "Rates Charged and Service Supplied By Telephone Utilities."

22.1(6) *Deregulation actions.*

a. The board, in the dockets shown in subparagraphs (1) to (14), deregulated the following services. Persons interested in determining the precise extent of deregulation in each docket should refer to the board dockets identified in this list. This list is provided for information only. Subsequent orders in these or other dockets may have modified the scope and manner of deregulation. Exclusion of an order or a statutory provision from this list in no way alters the effectiveness of such order or statutory provision.

(1) Inside station wiring including provisioning, repair, and maintenance. This included a revised definition of "demarcation point" in subrule 22.1(3). Docket No. RMU-81-19. Effective October 8, 1982.

(2) Terminal equipment including provision, installation, repair, and maintenance of all customer premises equipment. Docket No. RMU-82-1. Effective May 11, 1983.

(3) Centrex, Hi-Lo Capacity Intraexchange, and Hi Capacity Interexchange and Private Line. Docket No. RPU-84-8. Effective July 1, 1984.

(4) Coin-operated telephones. Pay telephones were determined to be a subset of deregulated terminal equipment. Docket Nos. RMU-85-6 and INU-84-6. Effective September 18, 1985.

(5) Riser cable (or cable for PBXs on the same premises) was found to be an extension of inside wiring. Ownership was transferred from the telephone utility to the premises owner. The telephone utility was compensated for the cable. Docket No. RMU-85-23. Effective April 30, 1986.

(6) Versanet Alarm Services Equipment. The remote module connecting an alarm panel to the local loop was determined to be deregulated terminal equipment. The Versanet equipment monitoring the signal was found to be competitive and deregulated. Docket No. INU-85-5. Effective May 16, 1986.

(7) Mobile telephone and paging services. Docket No. INU-86-2. Effective August 7, 1986.

(8) Billing and collection services (but not the recording function). Docket Nos. RMU-86-16 and INU-86-10. Effective October 15, 1986.

(9) InterLATA Interexchange Message Telecommunications Service (MTS), Wide Area Telecommunications Service (WATS), Channel Service (Private Line), and Custom Network Service (Software Defined Network Service, Megacom Services, Megacom 800 Service, and AT&T Readyline Service). Docket No. INU-88-2. Effective April 5, 1989, and July 19, 1990.

(10) Speed calling. Docket No. INU-88-8. Effective December 22, 1989.

(11) The recording function of billing and collection services. Docket No. INU-88-9. Effective January 9, 1990.

(12) Competitive IntraLATA Interexchange Services, InterLATA and IntraLATA ISDN, Operator Services, Directory Services, and Voice Messaging Service. Docket No. INU-95-3. Effective June 24, 1996.

(13) Local directory assistance. Docket No. INU-00-3. Effective February 23, 2001.

(14) Local exchange services found to be competitive and deregulated in the following exchanges: Armstrong, Coon Rapids, Council Bluffs, Delmar, Forest City, Harlan, Laurens, Lowden, Mapleton, Oxford, Oxford Junction, Primghar, Saint Ansgar, Solon, Spencer, Stacyville, Stanwood, Storm Lake, Tiffin, and Whiting. Docket No. INU-04-1. Effective December 23, 2004.

b. Deregulation resulting from 2005 Iowa Acts, chapter 9, section 1. Effective July 1, 2005, Iowa Code section 476.1D(1) was amended to deregulate the retail rates for most business and residential local exchange services with the exception of single line flat-rated residential and business service rates, at the election of each telephone utility. The affected utilities opted for deregulation as follows:

(1) Approval of Qwest Corporation’s replacement tariff. Qwest's replacement tariff removed the rates for most local exchange services from the tariff, with the exception of single line flat-rated residential and business service rates. Docket No. TF-05-167. Effective September 6, 2005.

(2) Approval of Frontier Communications of Iowa, Inc.’s replacement tariff. This replacement tariff removed the rates for most local exchange services from the tariff, with the exception of single line flat-rated residential and business service rates. Docket No. TF-05-181. Effective September 20, 2005.

(3) Approval of Iowa Telecommunications Services, Inc.'s, d/b/a Iowa Telecom, replacement tariff. This replacement tariff removed the rates for most local exchange services, with the exception of single line flat-rated residential and business service rates. Docket No. TF-05-182. Effective November 5, 2005.

(4) Single line flat-rated residential and business service rates were found to be competitive and deregulated in the following exchanges: Alta, Belle Plaine, Bennett, Cambridge, Carter Lake, Greene, Grundy Center, Guthrie Center, Hartley, Manning, Marble Rock, Marengo, Onawa, Orange City, Osage, Oyens, Paullina, Reinbeck, Slater, and Wapello. Docket No. INU-05-2. Effective December 5, 2005.

(5) Single line flat-rated residential and business service rates were deregulated pursuant to Iowa Code section 476.1D(1). Docket No. INU-08-1. Effective July 1, 2008.

[**ARC 7826B**, IAB 6/3/09, effective 7/8/09; **ARC 8871B**, IAB 6/30/10, effective 8/4/10]

199—22.2(476) Records and reports.

22.2(1) *Evaluation of records.* Each telephone utility has the obligation to continually study and evaluate its records and reports to ensure that any irregularities in service that may cause customer or user

dissatisfaction or complaint are corrected expeditiously and that all phases of construction, equipment maintenance or operation are satisfactory.

22.2(2) *Location and retention of records.* Unless otherwise specified in this chapter, all records required by these rules shall be kept and preserved in accordance with the applicable provisions of Chapter 18 of the board's rules, Utility Records.

Where a telephone utility is operated in conjunction with any other enterprise, suitable records shall be maintained so that the results of the telephone operation may be determined upon reasonable notice and request by the board.

22.2(3) *Tariffs to be filed with the board.* The utility, including an alternative operator services company, shall file its tariff with the board, and shall maintain such tariff filing in a current status. A copy of the same tariff shall also be on file in all business offices of the telephone utility and shall be available for inspection by the public.

The tariff shall be classified, designated, arranged, and submitted so as to conform to the requirements of this chapter or board order. Provisions of the schedules shall be definite and so stated as to minimize ambiguity or the possibility of misinterpretation. The form, identification, and content of tariffs shall be in accordance with these rules unless otherwise provided.

Utilities which are not subject to the rate regulation provided for by Iowa Code chapter 476 shall not file schedules of rates unless required by another rule or by board order. Nothing contained in these rules shall be deemed to relieve any utility of the requirement of furnishing any of these same schedules or contracts which are needed by the board in the performance of the board's duties upon request to do so by the board. Every telephone utility shall make the schedule of its rates readily available to customers on the utility's Web site, if the utility has one, or by mail, upon request.

22.2(4) *Form and identification.* All tariffs shall conform to the following rules.

a. The tariff shall be printed, typewritten or otherwise reproduced on 8½ × 11-inch sheets of white paper equal in durability to 20-pound bond paper with 25 percent cotton or rag content so as to result in a clear and permanent record. The sheets of the tariff should be ruled or spaced to set off a border on the left side suitable for binding. In the case of utilities subject to regulation by any federal agency the format of sheets of tariff as filed with the board may be the same format as is required by the federal agency, provided that the rules of the board as to title page; identity of superseding, replacing or revising sheets; identity of amending sheets; identity of the filing utility, issuing official, date of issue and effective date; and the words "Filed with the board" shall be applied to modify the federal agency format for the purposes of filing with this board.

b. The title page of every tariff and supplement shall show in the order named:

(1) The first page shall be the title page which shall show:

(Name of Public Utility)
Telephone Tariff
Filed with
Iowa Utilities Board
_____(date)

(2) When a tariff is to be superseded or replaced in its entirety, the replacing tariff shall show on its title page that it is a revision of a tariff on file.

(3) When a revision or amendment is made to a filed tariff, the revision or amendment shall show on each sheet the designation of the original tariff or the number of the immediate preceding revision or amendment which it replaces. (See exhibit A)

(4) When a new part of a tariff eliminates an existing part of a tariff it shall so state and clearly identify the part eliminated. (See exhibit A)

c. Any tariff modifications as defined above shall be marked in the right-hand margin of the replacing tariff sheet with symbols as here described to indicate the place, nature and extent of the change in text.

—Symbols—

(C)—Changed regulation
(D)—Discontinued rate or regulation
(I)—Increase in rate
(N)—New rate or regulation
(R)—Reduction in rate
(T)—Change in text only

d. All sheets except the title page shall have, in addition to the above-stated requirements, the following further information:

(1) (Name of public utility) Telephone Tariff under which shall be set forth the words "Filed with board." If the utility is not a corporation, and a trade name is used, the name of the individual or partners must precede the trade name.

(2) Issuing official and issue date.

(3) Effective date (to be left blank by rate-regulated utilities).

EXHIBIT A

. . . . . Telephone Tariff
(Name of Company)
Filed with board.

Part No. . . . . .
. . . . . Sheet No. . . . . .
Canceling (or revising). . . . . Sheet No. . . . . .
Amending . . . . . Sheet No. . . . . .

EXAMPLE

Issued . . . . . Effective. . . . . .
(Date) (Date)
By . . . . . .

22.2(5) *Content of tariffs.*

a. A table of contents listing tariff sections in the order in which they appear showing the sheet number of the first page of each rate schedule or other section. In the event the utility filing the tariff elects to segregate a section such as general rules from other sections, it may at its option prepare a separate table of contents or index for each such segregated section.

b. Local exchange utilities shall file a map which shall clearly define the base rate boundary and any rural or special zones that are set forth in the tariff. The boundary line location on such maps shall be delineated from fixed reference points.

c. The period during which the billed amount may be paid before the account becomes delinquent shall be specified. Where net and gross amounts are billed, the difference between net and gross is a late payment charge and the amount shall be specified.

d. Forms of standard contracts required of customers for the various types of service available other than those which are defined elsewhere in the tariff.

e. A designation, by exchange, of the EAS to other exchanges.

f. The list of exchange areas served.

g. Definitions of classes of customers.

h. Extension rules, under which extensions of service will be made, indicating what portion of the extension or cost thereof will be furnished by the utility; and if the rule is based on cost, the items of cost included as required in 22.3(6).

i. The type of construction which the utility requires the customer to provide if in excess of the Iowa electrical safety code or the requirements of the municipality having jurisdiction, whichever may be the most stringent in any particular.

j. Statement of the type of special construction commonly requested by customers which the utility allows to be connected, and the terms upon which such construction will be permitted, with

due provision for the avoidance of unjust discrimination as between customers who request special construction and those who do not. This applies, for example, to a case where a customer desires underground service in overhead territory.

k. Rules with which prospective customers must comply as a condition of receiving service.

l. Notice by customer required for having service discontinued.

m. Rules covering temporary service.

n. Rules covering the type of equipment which may or may not be connected.

o. Rules on billing periods, bill issuance, notice of delinquency, refusal of service, service disconnection and reconnection and customer account termination for nonpayment of bill.

p. Rescinded IAB 12/21/05, effective 1/25/06.

q. Customer deposit rules which cover when deposits are required, how the amounts of required deposits are calculated, requests for additional deposits, interest on deposits, records maintained, issuance of receipts to customers, replacement of lost receipts, refunds and unclaimed deposit disposition.

r. A separate glossary of all acronyms and trade names used.

s. A general explanation of each regulated service offering available from the utility.

t. to *v.* Rescinded IAB 12/21/05, effective 1/25/06.

22.2(6) *Information to be filed with the board.*

a. Each utility shall file with the board the name, title, address, and telephone number of the person who is authorized to receive, act upon, and respond to communications from the board in connection with the following:

(1) General management duties.

(2) Customer relations (complaints).

(3) Engineering operations.

(4) Outages, including those occurring during nonoffice hours, pursuant to paragraph 22.2(8)*"d."*

b. A copy of a new directory being distributed to customers.

22.2(7) *Universal service certification application.* Rescinded IAB 10/25/06, effective 11/29/06.

22.2(8) *Outage reporting requirements.* Rescinded IAB 2/10/10, effective 3/17/10.

This rule is intended to implement Iowa Code section 476.2.

[**ARC 7826B**, IAB 6/3/09, effective 7/8/09; **ARC 8516B**, IAB 2/10/10, effective 3/17/10]

199—22.3(476) General service requirements. The requirements of this rule do not apply to intrastate access service.

22.3(1) *Directories.* All directories published after the effective date of these rules shall conform to the following:

a. Telephone directories shall be published not less than annually, except for good cause shown, listing the name, address and telephone number of all customers unless otherwise requested by the customer. A local exchange carrier serving an exchange may choose not to publish a telephone directory if the local exchange carrier makes arrangements for publication in a directory that is commonly available in the local exchange in question.

b. Upon issuance, a copy of each directory shall be distributed without charge to all of the utility's customers locally served by that directory.

c. The year of issue or effective dates shall appear on the front cover and, if space permits, on the binding. Information pertaining to emergency calls, such as for the police and fire departments, for each exchange listed in the directory shall appear conspicuously on the front side of the first page of the directory. The directory shall also show a summary of the names of listed exchanges.

d. The directory shall contain such instructions concerning placing local and long distance calls, calls to repair and information services, and location of telephone company business offices as may be appropriate to the area served by the directory. A statement shall be included that the company will verify the condition of a line if requested by a customer and whether any charge will apply. The directory must indicate how to order 900 and 976 blocking and indicate that the first block is without charge. The directory shall contain descriptions of all current N11 services.

e. Directory assistance or intercept operators shall maintain records of all telephone numbers (except telephone numbers not listed or published at customer request) in the area for which they are responsible for furnishing information service.

f. In the event of an error or omission, in the name or number listing of a customer, that customer's correct name and telephone number shall be furnished to the calling party either upon request to or interception by the telephone company.

g. When additions or changes in plant, records, or operations which will necessitate a large group of number changes are scheduled, reasonable notice shall be given to all customers so affected even though the additions or changes may be coincident with a directory issue.

h. For any exchange in which an extended area call can terminate, the terminating exchange telephone utility shall provide all recently compiled directory listings, except listings for nonpublished or nonlisted customers, to the utility from which the extended area call originates. The telephone utility shall provide the directory listing without charge, within 30 days of receipt of a written request for those listings.

i. In addition to the serving exchange directory listing required under 22.3(1)*"a,"* upon the customer's request, an Iowa customer served by an out-of-state exchange shall be included in the directory list of one contiguous Iowa exchange of the customer's choice. Any charge for such Iowa listing shall be paid by the serving exchange.

22.3(2) *Service check.* Upon the individual customer's request, each telephone utility shall perform a service checkup to the demarcation point, without charge to the customer.

22.3(3) *Class of service.* Rescinded IAB 12/21/05, effective 1/25/06.

22.3(4) *Compliance.* Rescinded IAB 12/21/05, effective 1/25/06.

22.3(5) *Pay telephone services and facilities.* All telephone utilities shall make available to customers provisions for the interconnection of pay telephone equipment on the same basis as business service. A separate access line shall not be required for pay telephone equipment. Nonrate-regulated telephone utilities shall provide service consistent with this subrule, but the subrule shall not apply to the pricing by nonrate-regulated telephone utilities of access lines to pay telephones.

22.3(6) *Extension plan.* Each utility shall develop a plan, acceptable to the board, for the extensions of facilities, where they are in excess of those included in the regular rates for service and for which the customer shall be required to pay all or part of the cost. The cost required to be paid by the customer shall be the revenue received by the telephone utility for the extension of plant and shall include a grossed-up amount for the income tax effect of such revenue. The amount of tax shall be reduced by the present value of the tax benefits to be obtained by depreciating the property in determining the tax liability. This plan must be related to the investment that prudently can be made for the probable revenue. No utility shall make or refuse to make any extensions except as permitted by the approved extension plan.

22.3(7) Reserved.

22.3(8) *Traffic rules.* Rescinded IAB 12/21/05, effective 1/25/06.

22.3(9) *"Directory assistance."* Rescinded IAB 12/21/05, effective 1/25/06.

22.3(10) *Nonworking numbers.* All nonworking numbers shall be placed upon an adequate intercept where existing equipment allows.

22.3(11) *Assignment of numbers.*

a. No telephone number shall be reassigned to a different customer within 60 days from the date of permanent disconnect.

b. For customers assigned a new number within the exchange, the former working number intercept shall provide the new number to a calling party for not less than 60 days or until the issuance of a new directory. No new number information shall be provided if the customer so requests.

EXCEPTION: When a change in number is required by a telephone utility due to nonpayment of yellow page advertising, the intercept is not required to volunteer the new number to callers. The new number shall be provided to callers of the directory assistance operator.

c. If the number assigned a customer results in wrong number calls sufficient in volume to be a nuisance, the number shall be changed at no charge.

22.3(12) *Ordering and transferring of service.* The terms and conditions for ordering and transferring local exchange service shall be contained in the telephone utility's tariff.

22.3(13) *Basic local service.* Rescinded IAB 12/21/05, effective 1/25/06.

22.3(14) *Adjacent exchange service.* All local exchange utilities shall file tariffs which include provisions which allow customers to establish adjacent exchange service.

a. The tariffs shall require the customer to pay the full cost of establishing and maintaining the adjacent exchange service.

b. In addition, the tariffs may include all or part of the following service provisions:

(1) The subscriber shall subscribe to local exchange service in the primary exchange in addition to the adjacent exchange service.

(2) All toll messages shall be placed through the primary exchange, unless there is a service outage in that exchange.

(3) The primary exchange company shall bill for the adjacent exchange service and make appropriate settlement to the secondary exchange company, unless the primary exchange and the adjacent exchange agree to a different billing arrangement.

(4) Adjacent exchange service shall be restricted to only the residential class of service, unless a waiver is permitted by the board for a particular customer for good cause shown.

(5) Failure of the subscriber to comply with the tariff provisions related to adjacent exchange service shall make the subscriber subject to discontinuance of service after appropriate notice.

c. These adjacent exchange service rules shall not affect the terms under which a customer receives adjacent exchange service, if that customer was receiving adjacent exchange service prior to the effective date of these rules.

[**ARC 7826B**, IAB 6/3/09, effective 7/8/09]

199—22.4(476) Customer relations.

22.4(1) *Customer information.*

a. Each utility shall:

(1) Maintain up-to-date maps, plans, or records of its entire exchange systems. These maps shall be available for board examination at a location within Iowa during regular office hours and will be provided to the board upon request. These are not the same maps as the boundary maps described in subrule 22.20(3).

(2) Whenever a residential customer or prospective residential customer requests local exchange service from a utility, and the customer indicates a desire to be informed of the lowest priced service alternatives available for local exchange service, the utility shall inform that customer of the lowest priced alternative available from that utility, based only on monthly recurring rates for flat-rated services, at the relevant location.

(3) Notify customers affected by a change in rates or schedule classification.

(4) Furnish such additional information as the customer may reasonably request.

b. Inquiries for information or complaints to a utility shall be resolved promptly and courteously. Employees who receive customer telephone calls and office visits shall be qualified and trained in screening and resolving complaints, to avoid a preliminary recitation of the entire complaint to employees without ability and authority to act. The employee shall provide identification to the customer.

Unless a customer agrees to an alternative form of notice, local exchange utilities shall notify their customers, by bill insert or notice on the bill form, of the address and telephone number where a utility representative qualified to assist in resolving the complaint can be reached. The bill insert or notice shall also include the following statement: "If (utility name) does not resolve your complaint, the service may be subject to state regulation. You may request assistance from the Iowa Utilities Board by writing 1375 E. Court Avenue, Room 69, Des Moines, Iowa 50319-0069, by calling (515)725-7321 or toll-free 1-877-565-4450, or E-mail to customer@iub.iowa.gov."

The bill insert or notice on the bill will be provided no less than annually. A telephone utility which provides local exchange service and issues an annual directory shall publish the information set forth above in its directory in addition to a mailing.

22.4(2) *Customer deposits.* Each utility may require from any customer or prospective customer a deposit intended to guarantee payment of bills for service based on the customer's credit history. No deposit other than for local exchange service is required to obtain local exchange service. The deposit must reflect the limits as to low-income customers in 199—subparagraph 39.3(2)*"b"*(4).

a. Deposits for local exchange service shall not be more in amount than the maximum charge for two months of local exchange service, or as may reasonably be required by the utility in cases involving service for short periods of time or special occasions. The deposit amounts must also reflect the limits as to low-income customers in 199—subparagraph 39.3(2)*"b"*(4).

b. Interest on customer deposits. Interest on such deposits shall be computed at 4.0 percent per annum, compounded annually. Interest shall be paid for the period beginning with the date of deposit to the date of refund or to the date that the deposit is applied to the customer's account, or to the date the customer's bill becomes permanently delinquent. The date of refund is that date on which the refund or the notice of deposit refund is forwarded to the customer's last-known address. The date a customer's bill becomes permanently delinquent, relative to an account treated as an uncollectible account, is the most recent date the account became delinquent.

c. Each utility shall keep records to show:

(1) The name and address of each depositor.

(2) The amount and date of the deposit.

(3) Each transaction concerning the deposit.

d. Each utility shall issue a receipt of deposit to each customer from whom a deposit is received. An itemized statement on the customer's bill may be considered an appropriate receipt. Each utility shall also provide means whereby a depositor may establish claim if the receipt is lost.

e. The deposit shall be refunded after not more than 12 consecutive months of prompt payment (which may be 11 timely payments and one automatic forgiveness of late payment). The account shall be reviewed after 12 months of service and if the deposit is retained it shall again be reviewed at the end of the utility's accounting year or on the anniversary date of the account.

f. Unclaimed deposits. The utility shall make a reasonable effort to return each unclaimed deposit and accrued interest after the termination of the services for which the deposit was made. The utility shall maintain a record of deposit information for at least two years or until such time as the deposit, together with accrued interest, escheats to the state pursuant to Iowa Code section 556.4, at which time the record and deposit, together with accrued interest less any lawful deductions, shall be sent to the state treasurer pursuant to Iowa Code section 556.11.

g. Unclaimed deposits, together with accrued interest, shall be credited to an appropriate account.

h. A new or additional deposit for local exchange service may be required to cover the amount provided in *"a"* above when a deposit has been refunded or the customer's payment history demonstrates a deposit is or continues to be appropriate. Written or verbal notice shall be provided advising the customer of any new or additional deposit requirement. The customer shall have no less than 12 days from the date of written or verbal notice to comply. The new or additional deposit may be payable electronically or by cash or check at any of the utility's business offices or local authorized agents. An appropriate receipt shall be provided. No written notice is required to be given of a deposit required as a prerequisite for commencing initial service.

i. A customer who fails to pay a new or additional deposit for local exchange service may be disconnected under the provisions of the written notice and 22.4(5).

22.4(3) *Customer billing, timely payment, late payment charges, payment and collection efforts.* Each utility's tariff rules shall comply with these minimum standards.

a. Billing to customers shall be scheduled monthly except upon mutual agreement of the customer and utility. A utility with unusual circumstances may obtain authority from the board for billing at other than monthly intervals.

b. Rescinded IAB 2/6/91, effective 3/13/91.

c. Paper bills shall be issued and delivered via U.S. mail unless the customer agrees to electronic or other billing pursuant to terms specified by tariff or customer agreement. Except as otherwise noted, the requirements of this subrule apply to both paper and electronic bills. The bill form or a bill insert shall provide the following information:

(1) The bill date and the bill due date for local exchange services, service charges, and other telecommunications services.

(2) The last date for timely payment shall be clearly shown and shall be not less than 20 days after the bill is rendered. For a paper bill, the bill shall be considered rendered to the customer when deposited in the U.S. mail with postage prepaid. For an electronic bill, the bill shall be considered rendered to the customer on the date of transmission to the last-known E-mail address or as otherwise defined in an agreement between the customer and utility. If the delivery of a paper bill is by other than U.S. mail, the bill shall be considered rendered when delivered to the last-known address of the party responsible for payment. If a bill cannot be transmitted electronically, the utility shall issue a paper bill. The utility may charge an appropriate amount for the distribution of a paper bill so long as the same amount is discounted should the customer choose electronic billing. When a customer changes from paper billing to electronic billing, the utility shall be allowed one complete billing cycle to make adjustments for electronic billing credits.

(3) Bills to customers shall be rendered regularly and shall contain a clear listing of all charges. A written, itemized listing of the services to which the customer subscribes and the monthly rates for those services shall be provided as part of the initial bill or when service is ordered and subsequently upon reasonable request of the customer.

(4) Each disconnection notice shall state that access to local exchange service shall not be denied for failure to pay for deregulated services.

(5) The requirements of subparagraph (1) above shall not apply to calls billed by interexchange utilities, including AOS companies.

(6) The requirements of subparagraphs (2), (3) and (4) above shall not apply to calls billed to a commercial credit card.

d. Rescinded IAB 6/3/09, effective 7/8/09.

e. Unless the terms of a multistate customer contract state otherwise, when the customer makes a partial payment in a timely manner, and does not designate the service or product for which payment is made, the payment shall first be applied to the undisputed balance for local exchange service. If an amount remains, it may then be applied to other services.

f. Each account shall be granted not less than one complete forgiveness of a late payment charge each calendar year. The utility's rules shall be definitive that on one monthly bill in each period of eligibility, the utility will accept the net amount of such bill as full payment for such month after expiration of the net payment period. The rules shall state how the customer is notified the eligibility has been used. Complete forgiveness prohibits any effect upon the credit rating of the customer or collection of late payment charge.

g. All residential customers shall be permitted to have a last date for timely payment changeable for cause in writing; such as, but not limited to, 15 days following the approximate date each month upon which income is received by the person responsible for payment.

h. Maximum payment required for installation and activation of local exchange service shall comply with the total derived in accord with these rules and the filed tariff.

(1) An applicant for local exchange service, who under the tariff credit rules is required to make a deposit to guarantee payment of bills, may be required to pay the service charges and deposit prior to obtaining service.

(2) The amounts required must comply with 22.4(2), 22.4(5) and 22.4(7).

i. Maximum payments required by an active account or inactive account, for restoration of service of the same class and location as existed prior to disconnection, shall be the total of charges derived for reconnection and must comply with 22.4(2), 22.4(5) and 22.4(7). Only charges specified in the filed tariff shall be applied.

j. The utility may initiate collection efforts with the issuance of a final bill when the termination of service is at the customer's request. For all other bills no collection effort other than rendering of the bill shall be undertaken until the delinquency date.

k. Undercharges. The time period for which a utility may back bill a customer for undercharges shall not exceed five years unless otherwise ordered by the board.

l. Overcharges. The time period for which the utility is required to refund or credit the customer's bill shall not exceed five years unless otherwise ordered by the board. Refunds to current customers may be in the form of bill credits, unless the refund exceeds $50 and the customer requests a refund in the same manner by which the bill was originally paid. Refunds to former customers may be made in the same manner by which the bill was originally paid. Refunds for local exchange service may not be applied to unpaid amounts for unregulated services.

22.4(4) *Customer complaints.*

a. Complaints concerning the charges, practices, facilities, or service of the utility shall be investigated promptly and thoroughly. The utility shall keep a record of such complaint showing the name and address of the complainant, the date and nature of the complaint, its disposition, and all other pertinent facts dealing with the complaint, which will enable the utility to review and analyze its procedure and actions. The records maintained by the utility under this rule shall be available for a period of two years for inspection by the board or its staff upon request.

b. Each utility shall provide in its filed tariff a concise, fully informative procedure for the resolution of all customer complaints.

c. The utility shall take reasonable steps to ensure that customers unable to travel shall not be denied the right to be heard.

d. The final step in a complaint hearing and review procedure shall be a filing for board resolution of the issues.

22.4(5) *Refusal or disconnection of service.* Notice of a pending disconnection shall be rendered and local exchange service shall be refused or disconnected as set forth in the tariff. The notice of pending disconnection required by these rules shall be a written notice setting forth the reason for the notice, and the final date by which the account is to be settled or specific action taken.

The notice shall be considered rendered to the customer when deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the notice shall be considered rendered when delivered to the last-known address of the person responsible for payment for the service. The final date shall be not less than five days after the notice is rendered.

One written notice, including all reasons for the notice, shall be given where more than one cause exists for refusal or disconnection of service. This notice shall include a toll-free or collect number where a utility representative qualified to provide additional information about the disconnection can be reached. The notice shall also state the final date by which the account is to be settled or other specific action taken. In determining the final date, the days of notice for the causes shall be concurrent.

Service may be refused or disconnected for any of the reasons listed below. Unless otherwise stated, the customer shall be provided notice of the pending disconnection and the rule violation which necessitates disconnection. Furthermore, unless otherwise stated, the customer shall be allowed a reasonable time in which to comply with the rule before service is disconnected. Except as provided in 22.4(5)*"a," "b," "c," "d,"* and *"e,"* no service shall be disconnected on the day preceding or the day on which the utility's local business office or local authorized agent is closed. Service may be refused or disconnected:

a. Without notice in the event of a condition on the customer's premises determined by the utility to be hazardous.

b. Without notice in the event of customer's use in such a manner as to adversely affect the utility's equipment or the utility's service to others.

c. Without notice in the event of tampering with equipment furnished and owned by the utility.

d. Without notice in the event of unauthorized use.

e. For violation of or noncompliance with the utility's rules on file with the board, the requirements of municipal ordinances or law pertaining to the service.

f. For failure of the customer or prospective customer to furnish service equipment, permits, certificates or rights-of-way specified to be furnished in the utility's rules filed with the board as conditions for obtaining service, or for the withdrawal of that same equipment or the termination of those permissions or rights, or for the failure of the customer or prospective customer to fulfill the contractual obligations imposed upon the customer as conditions of obtaining service by a contract filed with and subject to the regulatory authority of the board.

g. For failure of the customer to permit the utility reasonable access to its equipment.

h. For nonpayment of bill or deposit, except as restricted by 22.4(7), provided that the utility has made a reasonable attempt to effect collection and:

(1) Has provided the customer with 5 days' prior written notice with respect to an unpaid bill and 12 days' prior written notice with respect to an unpaid deposit, as required by this rule; disconnection may take place prior to the expiration of the 5-day unpaid bill notice period if the utility determines, from verifiable data, that usage during the 5-day notice period is so abnormally high that a risk of irreparable revenue loss is created.

(2) Is prepared to reconnect the same day if disconnection is scheduled for a weekend, holiday or after 2 p.m.

(3) In the event of a dispute concerning the bill, the telephone company may require the customer to pay a sum of money equal to the amount of the undisputed portion of the bill. Following payment of the undisputed amount, efforts to resolve the complaint, using complaint procedures in the company's tariff, shall continue and for not less than 45 days after the rendering of the disputed bill, the service shall not be disconnected for nonpayment of the disputed amount. The 45 days may be extended by up to 60 days if requested of the utility by the board in the event the customer files a written complaint with the board.

22.4(6) *Medical emergency.* Disconnection of a residential customer shall be postponed 30 days if an existing medical emergency of the customer, a member of the customer's family, or any permanent resident of the premises where service is rendered would present an especial danger to the health of any permanent resident of the premises. Indicators of an especial danger to health include, but are not limited to: age; infirmity; mental incapacitation; serious illness; physical disability, including blindness and limited mobility; and any other factual circumstance which may indicate a severe or hazardous health situation. The telephone utility may require written verification of the especial danger to health by a physician or a public health official, including the name of the person endangered, and a statement that the person is a resident of the premises in question. Initial verification may be by telephone, but the telephone utility may require a written verification within 5 days of the verification of the especial health danger by the physician or a public health official, including the name of the person endangered and a statement that the person is a resident of the premises in question. If the service has been disconnected within 14 days prior to verification of illness for a qualifying resident, service shall be restored to that residence if a proper verification is thereafter made in accordance with the foregoing provisions. If the customer does not make payment during the 30-day period, the service is then subject to disconnection pursuant to subrule 22.4(5).

22.4(7) *Insufficient reasons for refusal, suspension, or discontinuance of service.* The following shall not constitute sufficient cause for refusal, suspension, or discontinuance of local exchange service to a present or prospective customer:

a. Delinquency in payment for service by a previous occupant of the premises to be served.

b. Failure to pay for terminal equipment, inside station wiring or other merchandise purchased from the utility.

c. Failure to pay for a different type or class of public utility service.

d. Failure to pay the bill of another customer as guarantor thereof.

e. Permitting another occupant of the premises access to the telephone utility service when that other occupant owed an uncollectible bill for service rendered at a different location.

f. Failure to pay for yellow page advertising.

g. Failure to pay for deregulated services other than local exchange service.

22.4(8) *Temporary service.* When the utility renders temporary service to a customer, it may require that the customer bear all the cost of installing and removing the service facilities in excess of any salvage realized.

[**ARC 7826B**, IAB 6/3/09, effective 7/8/09; Editorial change: IAC Supplement 12/29/10]

199—22.5(476) Telephone utility service standards.

22.5(1) *Requirement for good engineering practice.* The telephone plant of the utility shall be designed, constructed, installed, maintained and operated subject to the provisions of the Iowa electrical safety code as defined in 199 IAC Chapter 25 and in accordance with accepted good engineering practice in the communication industry to ensure, as far as reasonably possible, continuity of service, uniformity in the quality of service furnished, and the safety of persons and property.

22.5(2) *Adequacy of service.*

a. Each local exchange utility and alternative operator services company shall employ prudent management and engineering practices so that sufficient equipment and adequate personnel are available at all times, including average busy-hour of the busy-season.

b. Each local exchange utility and alternative operator services company shall conduct traffic studies, employ reasonable procedures for forecasting future service demand, and maintain records necessary to demonstrate to the board that sufficient equipment is in use and that an adequate operating force is provided.

c. Each utility shall employ adequate procedures for assignment of facilities. The assignment record shall be kept up-to-date and checked periodically to determine if adjustments are necessary to maintain proper balance in all trunk and equipment groups. The records shall be available for review by the board upon request.

d. The criteria established in these rules define a minimal acceptable standard for the most basic elements of telecommunications service. The rules do not include all criteria and they do not establish the most desirable service level for any basic element. If a specific element is not covered, the provider must meet generally accepted industry standards for that element. Total service must also meet generally accepted industry standards.

e. The standards within these rules establish the minimum acceptable quality of service under normal operating conditions. They do not establish a level of performance to be achieved during the periods of emergency, catastrophe affecting large numbers of customers, nor do they apply to extraordinary or abnormal conditions of operation, such as those resulting from work stoppage, civil unrest, or other events.

22.5(3) *Central office requirements.*

a. Each local exchange utility shall employ appropriate procedures to determine the adequacy of central office equipment. Sufficient central office capacity and equipment shall be provided to meet the following minimum requirements during average busy-season, busy-hour:

(1) Dial tone within three seconds for 98 percent of call attempts on the switched network.

(2) Complete dialing of called numbers on at least 97 percent of telephone calls without encountering an all-trunks-busy condition within the central office.

(3) At least 98 percent of all correctly dialed interoffice local calls shall not encounter an all-trunks-busy condition.

(4) At least 98 percent of all correctly dialed calls offered to any trunk group within an EAS calling area will not encounter an all-trunks-busy condition.

b. Each local exchange utility shall engineer all central office equipment using sound engineering practice, consistent with the practices of the telephone industry. All new central offices shall be engineered on a terminal-per-station basis.

c. Rescinded IAB 6/3/09, effective 7/8/09.

d. Each central office shall be provided with alarms on a 24-hour basis to indicate improper functioning of equipment. All alarms shall be transmitted to an alarm center or to a location that will receive and respond to the alarm condition as set forth in the Utilities Emergency/Disaster Plan on a

24-hour, seven-day-a-week basis. All alarms and alarm sensors must be tested and reported internally on a regular basis, not to exceed six months.

22.5(4) *Telecommunication circuits.* All circuits shall be properly constructed and maintained to ensure quality service.

22.5(5) *Interexchange trunks.* Trunks for extended area service shall be provided so that at least 98 percent of telephone calls will not encounter an all-trunks-busy condition.

22.5(6) *Loop transmission requirements.* Local exchange utilities shall furnish and maintain adequate plant, equipment, and facilities to provide satisfactory transmission of communications between users in their service areas. Transmission shall be at adequate volume levels and free of excessive distortion. Levels of noise and cross talk shall be such as not to impair communications.

22.5(7) *Minimum transmission objectives.*

a. The transmission objectives set forth are based upon the use of standard telephone stations connected to a 48-volt dial central office, and measured at a frequency of 1,000 hertz.

b. Lines shall have a loop resistance not exceeding the operating design of the associated central office equipment, unless long line adapters and amplifiers or special equipment are used.

c. All loop measurements shall be taken across tip and ring and to ground at the demarcation point excluding all inside wiring and terminal equipment.

(1) Loop current shall be acceptable above 20 mA.

(2) Circuit loss shall be measured at 1004 KHz at 0 dBm from the central office. The acceptable level shall be 0 to—8 dBm with a maintenance margin not to exceed 8.5 dB.

(3) Circuit noise shall be measured on a quiet (balanced) termination from the central office. The acceptable level shall be less than 20 dBrnC, the marginal level between 20 and 30 dBrnC, and unacceptable above 30 dBrnC.

(4) Power influence level shall be acceptable from 0 to 80 dBrnC, marginal from 80 to 90 dBrnC, and unacceptable above 90 dBrnC. Although the communication utility has the requirement to meet this objective, the communication and electric utilities shall cooperate in mitigating the effects of AC power induction.

d. Whenever feasible, the overall transmission loss, including terminating equipment, on intertandem trunks should be 6 dB for an all digital connection. Overall transmission loss, including terminating equipment on intertandem trunks should not exceed 9 dB for a composite digital and analog connection. This measurement shall be taken at 1004 Hz.

(1) The transmission objectives set forth are based upon measurements at the customer's network interface device with the customer premise disconnected.

(2) The transmission loss as set forth means the loss that occurs in a telecommunication connection measured in decibels (dB) at 1004 Hz exclusive of rest pads, impedance matching coils used for measuring and similar devices.

(3) A customer line shall, in general, have loop resistance not exceeding the operating design of the associated central office equipment. Amplifiers and long line adapters may be used to extend the central office design limits.

(4) A minimum line current of 20 mA DC is acceptable.

(5) The customer line (loop) shall be designed for a maximum loss of 8.0 dB at 1004 Hz to be measured from the customer demarcation to the central office one milliwatt test tone supply.

(6) The actual measured loss of the customer loop shall not exceed 9.0 dB from the customer demarcation to the central office one milliwatt test tone supply. A loss greater than 9.0 dB is unacceptable, requiring immediate action.

(7) Circuit noise is to be measured on a quiet termination from the central office. The acceptable level is not to exceed 20 dBrnC. The marginal level is between 20 dBrnC and 30 dBrnC. Any measurement exceeding 30 dBrnC is unacceptable, requiring immediate action.

22.5(8) *Joint use.* Where joint construction is mutually agreed upon, it shall be subject to the provisions of the Iowa electrical safety code and the requirement for good engineering practice found in subrule 22.5(1).

22.5(9) *Provisions for testing.* Each telephone utility shall provide or have access to test facilities which will enable it to determine the operating and transmission capabilities of circuit and switching equipment, either for routine maintenance or for fault location.

22.5(10) *Operator-assisted calls.* These operator services rules shall apply to all local exchange utilities, interexchange utilities, and alternative operator services companies which provide operator services.

a. All communications between customers must be considered as confidential in nature. The provider shall take reasonable action to minimize the potential access of other entities to those communications. Operators or employees of the provider must not listen to any conversation between customers except when an operating necessity. Operators shall not repeat or divulge the nature of any local or long distance conversation, nor divulge any information inadvertently overheard. Providers will be held responsible for strict compliance with this rule by their employees or other entities which perform this service for the provider.

b. Suitable rules and instructions shall be adopted by each provider and followed by employees or other entities employed by the provider governing the language and operating methods to be used by operators during assistance to customers. Any required call timing for regulated operator-assisted calls shall accurately record when the customer-requested connection is established and when it is terminated.

c. Each provider offering operator assistance to the public shall provide a service that can answer 90 percent of directory, intercept, toll, and local assistance calls within ten seconds. On the average, calls shall be answered within five seconds.

d. Rescinded IAB 6/3/09, effective 7/8/09.

e. An answer shall mean that the operator is ready to accept information necessary to process the call. An acknowledgment that the customer is waiting on the line shall not constitute an answer.

f. All operators receiving 0 - and 911 calls shall be capable of connecting calls to appropriate emergency services at all hours. All operator services providers shall have a board-approved methodology to ensure the routing of all emergency zero-minus (0 -) calls in the fastest possible way to the proper local emergency service agency.

g. Third-party billing from identified public pay telephones and reverse charges from all telephones will be allowed:

(1) If the person or device answering responds positively that the charges will be accepted, with the provision that remaining on the line does not constitute a positive response;

(2) On reverse charges, when it is apparent the voice on the answering machine is the caller's voice; and

(3) On a third-party billing, when it is apparent the voice on the answering machine at the billing number is the caller's voice.

22.5(11) *Maintenance of plant and equipment.*

a. Each telephone utility shall adopt and pursue a program of periodic inspection, testing, and preventive maintenance aimed at achieving efficient operation of its system to permit the rendering of safe, adequate and continuous service at all times.

b. Maintenance shall include keeping all plant and equipment in a good state of repair consistent with safe and adequate service performance. Broken, damaged or deteriorated parts which are no longer serviceable shall be repaired or replaced. Adjustable apparatus and equipment shall be readjusted promptly when found by preventive routines or fault location tests to be in unsatisfactory operating condition. Electrical faults, such as leakage or poor insulation, noise induction, cross talk, or poor transmission characteristics shall be promptly corrected to the extent practicable within the design capability of the plant affected when located or identified.

c. In all exchanges, periodic leakage tests shall be made on all circuits by use of proper instruments to determine that sufficient insulation is being maintained and further to discover any substantial change in insulation values which might cause future service difficulties. Loop resistance and transmission tests should be made on local circuits when transmission is poor, in an endeavor to locate the source of trouble.

d. Central office batteries shall be replaced when required to maintain good telephone service.

e. Central office equipment shall be inspected and routinely tested at regular intervals, and any necessary repairs, adjustments or replacements made to ensure the proper functioning of switching equipment.

f. All regulated outside plant facilities shall be properly maintained including replacement of equipment when broken, damaged, or when necessary for good transmission.

g. Records of various tests and inspections shall be kept on file in the office of the telephone utility for a minimum of one year. These records shall show the line or regulated equipment tested or inspected, the reason for the test, the general conditions under which the test was made, the general result of the test, and any corrections made.

22.5(12) Reserved.

22.5(13) *Terminating access blocking.* Rescinded IAB 12/21/05, effective 1/25/06.

22.5(14) *Information service access blocking.* Each local exchange utility shall include in its tariff on file with the board a provision giving its subscribers the option of blocking access to all 900 and 976 prefix numbers, without charge for the first block.

[**ARC 7826B**, IAB 6/3/09, effective 7/8/09]

199—22.6(476) Standards of quality of service. The local exchange utility using its facilities to provide primary service will measure its service connection, held order, and service interruption performance monthly according to subrules 22.6(1), 22.6(2), and 22.6(3). Records of the measurements and any summaries thereof, by individual wire centers, will be provided upon request of the board. Records of these measurements will be retained by the utility for two years.

22.6(1) *Service connection.* Each local exchange utility using its facilities to provide service shall make all reasonable efforts to maintain a five-business-day standard for primary connection service or within the customer-requested service connection date. All reasonable efforts to maintain the above standard shall be measured by the following:

a. Eighty-five percent of all customers provided service within five business days of the request or the customer-requested date, whichever is later. Compliance will be measured based on a three-month rolling average.

b. Ninety-five percent of all customers provided service within ten business days of the request or the customer-requested date, whichever is later. Compliance will be measured based on a three-month rolling average.

c. Ninety-nine percent of all customers provided service within 30 business days of the request or the customer-requested date, whichever is later. Compliance will be measured based on a three-month rolling average.

22.6(2) *Held orders.*

a. During such period of time as a local exchange utility using its facilities to provide service may not be able to supply primary telephone service to prospective customers within five business days after the date applicant desires service, the telephone utility shall keep a record, by exchanges, showing the name and address of each applicant for service, the date of application, the date that service was requested, and the class of service applied for, together with the reason for the inability to provide new service to the applicant.

b. When, because of a shortage of facilities, a utility is unable to supply primary telephone service on the date requested by applicants, first priority shall be given to furnishing those services which are essential to public health and safety. In cases of prolonged shortage or other emergency, the board may require establishment of a priority plan, subject to its approval for clearing held orders, and may request periodic reports concerning the progress being made.

c. When the local exchange utility using its facilities to provide service fails to provide primary local exchange service to any customer requesting service within 15 business days, the local exchange utility shall provide the customer with an alternative form of service until primary local exchange service can be provided. The alternative form of service provided shall be wireless telephone service unless the customer agrees otherwise.

d. If an alternative form of primary service is provided, the local exchange utility is authorized to charge the customer the regular rates (if applicable) for the alternative primary service ordered, if such rates are less than the regulated rate for primary local exchange service. Otherwise, the customer will be charged the regulated rate for primary local exchange service. Where an alternative form of service is impossible to provide, the facilities-based local exchange utility shall waive all usual installation charges and, once primary local exchange service is provided, shall credit the customer's account in an amount equal to the pro-rata monthly primary local exchange charge for each day service was not provided.

22.6(3) *Service interruption.*

a. Each telephone utility using its facilities to provide primary service shall make all reasonable efforts to prevent interruptions of service. When interruptions are reported or found by the utility to occur, the utility shall reestablish service with the shortest possible delay. Priority shall be given to a residential customer who states that telephone service is essential due to an existing medical emergency of the customer, a member of the customer's family, or any permanent resident of the premises where service is rendered. All reasonable efforts shall be measured by the following:

(1) Eighty-five percent of all out-of-service trouble reports cleared within 24 hours. Compliance will be measured based on a three-month rolling average.

(2) Ninety-five percent of all out-of-service trouble reports cleared within 48 hours. Compliance will be measured based on a three-month rolling average.

(3) One hundred percent of all out-of-service trouble reports cleared within 72 hours.

(4) The response time for all utilities responsible to test and attempt to correct any interexchange trunk problem, except a total outage, shall be within 24 hours after the problem is reported. If the problem is not corrected within that time, the utility responsible for doing so shall keep all other affected telephone utilities advised as to the current status on a daily basis. For a total outage, the response time shall be immediate.

b. Arrangements shall be made to have adequate personnel and equipment available to receive and record trouble reports and also to clear trouble of an emergency nature at all times.

c. Calls directed to the published telephone numbers for service repair or the business offices of the telephone utility shall be acknowledge within 20 seconds for 85 percent of all such calls and within 40 seconds for 100 percent of all such calls.

d. If a customer's service must be interrupted due to maintenance, the utility shall notify the affected customer, in advance, if possible. The company shall perform the work to minimize inconvenience to the customer and strive to avoid interruptions when there is conversation on the line.

e. Each telephone utility shall keep a written record showing all interruptions affecting service in a major portion of an exchange area for a minimum of six years. This record shall show the date, time, duration, time cleared and extent and cause of the interruption. This record shall be available to the board upon request.

f. Whenever a trouble report is received, a record shall be made by the company and if repeated within a 30-day period by the same customer, the case shall be referred to an individual for permanent correction.

g. When a customer's service is reported or is found to be out of order, it shall be restored as promptly as possible.

h. Each local exchange utility using its facilities to provide service shall maintain its network to reasonably minimize customer trouble reports. The rate of customer trouble reports on the company side of the demarcation point will not exceed four per 100 access lines per month per wire center.

i. When a subscriber's service is interrupted and remains out of service for more than 24 consecutive hours after being reported to the local exchange company or being found by the company to be out of order, whichever occurs first, the company shall make appropriate adjustments to the subscriber's account. This rule does not apply if the outage occurs as a result of:

(1) A negligent or willful act on the part of the subscriber;

(2) A malfunction of subscriber-owned telephone equipment;

(3) Disasters or acts of God; or

(4) The inability of the company to gain access to the subscriber's premises.

The adjustment, either a direct payment or a bill credit, shall be the proportionate part of the monthly charges for all services and facilities rendered inoperative during the interruption. The adjustment shall begin with the hour of the report or discovery of the interruption. Adjustments not in dispute shall be rendered within two billing periods after the billing period in which the interruption occurred.

22.6(4) *Repair—missed appointments.* When a utility makes an appointment for installation or repair within a given range of time, and misses that appointment by over an hour, the customer will receive one month's primary local service free of charge. This is applicable to each missed appointment.

22.6(5) *Emergency operation.*

a. Each telephone utility shall make reasonable provisions to meet emergencies resulting from failures of power service, climate control, sudden and prolonged increases in traffic, illness of operators, or from fire, explosion, water, storm, or acts of God, and each telephone utility shall inform affected employees, at regular intervals not to exceed one year, of procedures to be followed in the event of emergency in order to prevent or mitigate interruption or impairment of telephone service.

b. All central offices shall have adequate provision for emergency power. Each central office shall contain a minimum of two hours of battery reserve. For offices without permanently installed emergency power facilities, there shall be access to a mobile power unit with enough capacity to carry the load which can be delivered on reasonably short notice and which can be readily connected.

c. An auxiliary power unit shall be permanently installed in all toll centers and at all exchanges exceeding 4,000 access lines.

d. Each local exchange utility shall maintain and make available for board inspection, its current plans for emergency operations, including the names and telephone numbers of the local exchange utility's disaster services coordinator and alternates.

22.6(6) *Business offices.*

a. Each local exchange utility shall have one or more business offices or customer service centers staffed to provide customer access in person or by telephone to qualified personnel, including supervisory personnel where warranted, to provide information relating to services and rates, accept and process applications for service, explain charges on customers' bills, adjust charges made in error, and, generally, to act as representatives of the local exchange utility. If one business office serves several exchanges, toll-free calling from those exchanges to that office shall be provided.

b. Upon the closing of any local exchange utility's public business office, the company must provide to the board, in writing, at least 30 days prior to the closing of the office the following information:

(1) The exchange(s) and communities affected by the closing;

(2) The date of the closing;

(3) A listing of other methods and facility locations available for payment of subscribers' bills in the affected exchanges; and

(4) A listing of other methods and locations available for obtaining public business office services.

[**ARC 7826B**, IAB 6/3/09, effective 7/8/09]

199—22.7(476) Safety.

22.7(1) *Protective measures.*

a. Each utility shall exercise reasonable care to reduce the hazards to which its employees, its customers or users and the general public may be subjected.

b. The utility shall give reasonable assistance to the board in the investigation of the cause of accidents and in the determination of suitable means of preventing accidents.

c. Each utility shall maintain a summary of all reportable accidents arising from its operations.

22.7(2) *Safety program.* Each utility shall adopt and execute a safety program, fitted to the size and type of its operations. As a minimum, the safety program should:

a. Require employees to use suitable tools and equipment in order that they may perform their work in a safe manner.

b. Instruct employees in safe methods of performing their work.

c. Instruct employees who, in the course of their work, are subject to the hazard of electrical shock, asphyxiation or drowning, in accepted methods of artificial respiration.

199—22.8(476) Nontoll interexchange trunking service (EAS) survey procedure.

22.8(1) *General information.*

a. The nontoll interexchange trunking service (EAS) survey procedures shall be followed by all telephone companies subject to the service jurisdiction of this board. The procedures in 22.8(2) and 22.8(3) shall be followed to establish EAS. The procedures in 22.8(4) and 22.8(5) shall be followed in order to discontinue EAS. There is no need to follow these procedures if there will be no rate increase associated with new EAS.

b. At all stages of this procedure the information required to be supplied to customers shall be sufficient to explain the required items to the customers, yet the information shall be in a form which is sufficiently brief not to confuse the customers or discourage the customers from completing the survey.

c. Whenever an EAS survey is conducted, the company shall mail to each customer account (primary service listing) a survey letter explaining the purpose of the survey, and a postage-paid, company-addressed return postcard on which the customer can indicate the customer's preference.

d. The company shall provide the board, for its approval, a copy of the proposed text and format of the customer letter and ballot survey card. The board may require alterations or corrections before permission is granted to proceed with the actual survey of the customers.

22.8(2) *Procedures and requirements for establishing EAS studies.*

a. The initiative for EAS shall be in the form of a request presented to the company with evidence of support indicated by a petition signed by no less than 15 percent of the exchange customers. Only the person to whom the monthly bill is addressed may sign the petition. In the case of a business customer, only a duly authorized agent or representative may sign. Each signer shall include address and telephone number. Initiative for EAS may also come from the company or the board.

b. If the requirements of 22.8(2), paragraph *"a,"* are fulfilled, a point-to-point usage study should be used to determine if sufficient community interest exists. There should be an average of five or more calls per customer per month and more than 50 percent of the customers making at least two toll calls per month. If these basic criteria are not met, the request will be dismissed without further proceedings.

c. If the provisions of 22.8(2), paragraph *"b,"* have been met, additional customer calling studies, cost and revenue studies including loss of toll revenues may be conducted, and submitted to the board. The board shall determine the merits of proceeding with a customer survey.

d. Records shall be kept of this procedure to substantiate the steps taken by the company. These studies need not be undertaken more than once in any 18-month period.

22.8(3) *Procedures and requirements for customer survey to establish EAS.*

a. The customer survey for two-way EAS need not be taken more than once in any 18-month period and the survey letter should contain the following items:

(1) An explanation of the purpose of the survey.

(2) A statement which identifies by class and grade of service the existing rate, the amount of rate increase and the new rate associated with the addition of the proposed EAS.

(3) A statement that more than 65 percent of the customers returning ballots must vote in favor of the proposal before further action will be taken.

(4) A statement indicating the proposed date when service would be established which shall not be more than two years from the survey ballot return date, unless the delay is granted by the board due to the facility considerations.

(5) The date by which the ballot must be returned to be considered shall be a minimum of 10 days and a maximum of 20 days from the date on which the survey letter is mailed to the customer. The ballots shall not be counted for 3 days following the survey ballot return date to allow all return cards to clear the post office. Results of the survey shall be provided to the board within 15 days of the return date.

b. Ballot by return postcard. The postage-paid, company-addressed return postcard included with the customer survey letter should contain the following information:

(1) A statement explaining the EAS proposal being voted on as set out in the customer survey letter.

(2) A place for the customer to indicate whether customer favors or is opposed to the establishment of EAS.

(3) Lines designated for the customer's signature, telephone number and date.

c. The return ballot shall be retained by the company for at least two years and shall be available for review by the board staff during that time. After two years the ballots may be destroyed; however, the results of the survey as recorded from the return ballots shall be maintained for a period of five years.

d. If the customers in an exchange vote in favor of EAS to another exchange but concurrence in two-way EAS is not received from that second exchange then consideration may be given to one-way EAS. The same basic survey procedure shall be followed as provided herein, but the customer survey letter shall also include information concerning lack of concurrence on two-way service by the neighboring exchange and that another survey is being taken to determine interest in one-way calling.

22.8(4) *Procedures and requirements for discontinuing EAS.*

a. The initiative to discontinue EAS shall be in the form of a request presented to the company with evidence of support indicated by a petition signed by no less than 15 percent of the exchange customers. Only the person to whom the monthly bill is addressed may sign the petition. In the case of a business customer, only a duly authorized agent or representative may sign. Each signer must include address and telephone number. Initiative to discontinue EAS may also come from the company or the board.

b. Customer calling studies, cost and revenue studies may be conducted and submitted to the board. The board shall determine the merits of proceeding with a customer survey.

c. Records shall be kept of this procedure to substantiate the steps taken by the company. These studies need not be undertaken more than once in any 18-month period.

22.8(5) *Procedures and requirements for customer survey to discontinue EAS.*

a. The customer survey for two-way EAS need not be taken more than once in any 18-month period and the survey letter should contain the following items:

(1) An explanation of the purpose of the survey.

(2) A statement which identifies by class and grade of service the amount of rate decrease, if any, and the new rates associated with the proposed discontinuance of EAS.

(3) A statement that more than 65 percent of the customers returning ballots must vote in favor of the discontinuance proposal before further action will be taken.

(4) A statement indicating the proposed date when service would be discontinued (which shall not be more than six months from the survey ballot return date).

(5) The date by which the ballots must be returned to be considered. This return date shall be a minimum of 10 days and a maximum of 20 days from the date on which the survey letter is mailed to the customer. The ballots shall not be counted for 3 days following the survey ballot return date to allow all return cards to clear the post office. Results of the survey shall be provided to the board within 15 days of the return date.

b. Ballot by return postcard. The postage-paid, company-addressed return postcard included with the customer survey letter should contain the following information:

(1) A statement explaining the EAS proposal being voted on as set out in the customer survey letter.

(2) A place for the customer to indicate whether customer favors or is opposed to the discontinuance of EAS.

(3) Lines designated for the customer's signature, telephone number and date.

c. The return ballot shall be retained by the company for at least two years and shall be available for review by the board staff during that time. After two years, the ballot may be destroyed; provided, however, a record showing the results of the survey as recorded from the return ballots shall be maintained for a period of five years.

d. If the customers approve discontinuance of two-way EAS to another exchange and concurrence in that discontinuance cannot be obtained from the customers of the second exchange, consideration may be given to continuance of one-way EAS by that second exchange. The same basic survey procedure shall be followed as provided herein, but the customer survey letter shall also include a statement indicating that the neighboring exchange or its customers have voted to discontinue two-way EAS and that this survey is being taken to determine interest in one-way calling.

199—22.9(476) Terminal equipment. Terminal equipment is deregulated. Customers may secure terminal equipment through any provider.

199—22.10(476) Unfair practices. All unfair or deceptive practices related to customer provision of equipment are prohibited. Any failure to provide information to customers or to deal with customers who provide their own terminal equipment or inside station wiring or an alteration of the charges for or availability of equipment or services on that ground, unless specifically authorized by board order or rule and by the utility's tariff, shall constitute unfair or deceptive practices. In cases of equipment in compliance with Federal Communications Commission registration requirements, telephone utility personnel are prohibited from making any statement, express or implied, to, or which will reach, a customer or prospective customer that terminal equipment in compliance with Federal Communications Commission registration requirements cannot properly be attached to the telephone network. This does not apply to good-faith efforts to amend the Federal Communications Commission requirements.

The listing of unfair practices in this rule shall not limit the types of acts which may be found to be unfair nor shall those listed be used to establish decisional criteria operating to exempt any act otherwise unfair from the intent of this rule.

199—22.11(476) Inside station wiring standards.

22.11(1) *Construction by user limitation.* A user shall not be allowed to construct inside station wiring from a demarcation point or between two or more buildings on the same premises to obtain service from an exchange other than that by which the user would normally be served, excluding users being provided adjacent exchange service or foreign exchange service as provided in a company's tariff. Existing inside wiring obtaining local exchange service within another exchange boundary shall be disconnected by the user within ten days after receipt of written notification from the local exchange company.

22.11(2) *Standards applicable to inside station wiring.* The following technical standards must be complied with:

a. Applicable registration standards promulgated by the Federal Communications Commission.

b. 47 CFR Part 68.

c. Applicable national, state or local building and electrical codes, including National Electrical Code, as defined in 199—subrule 25.2(5); and accepted good engineering practice in the communication industry to ensure, as far as reasonably possible, continuity of service, uniformity in the quality of service furnished, and safety of persons and property.

199—22.12(476) Contents of tariff filings proposing rates.

22.12(1) *Construction of rule.* This rule shall be construed in a manner consistent with its purpose to expedite informed consideration of tariff filings proposing rates by ensuring the availability of relevant information on a standardized basis. Unless a waiver is granted prior to filing, this rule shall apply to all tariff filings by rate-regulated telephone utilities proposing rates, except the tariff filings of AOS utilities that propose rates at or below the corresponding rates for similar services of utilities whose rates have been approved by the board in a rate case or set in a market determined by the board to be competitive.

22.12(2) *Cost studies to be filed.* Rescinded IAB 6/3/09, effective 7/8/09.

22.12(3) *Specification of cost methodologies.* Rescinded IAB 6/3/09, effective 7/8/09.

22.12(4) Rescinded, effective June 10, 1987.

[**ARC 7826B**, IAB 6/3/09, effective 7/8/09]

199—22.13(476) Methodology for determining costs to serve. Rescinded IAB 6/3/09, effective 7/8/09.

199—22.14(476) Intrastate access charge application, tariff procedures, and rates.

22.14(1) *Application of intrastate access charges.*

a. Intrastate access charges shall apply to all intrastate access services rendered to interexchange utilities. Intrastate access charges shall not apply to EAS traffic. In the case of resale of services of interexchange utilities, access charges shall apply as follows:

(1) The interexchange utilities shall be billed as if no resale were involved.

(2) The resale carrier shall be billed only for access services not already billed to the underlying interexchange utility.

(3) Specific billing treatment and administration shall be provided pursuant to tariff.

b. Except as provided in 22.14(1)*"b"*(3), no person shall make any communication of the type and nature transmitted by telephone utilities, between exchanges located within Iowa, over any system or facilities, which are or can be connected by any means to the intrastate telephone network, and uses exchange utility facilities, unless the person shall pay to the exchange utility or utilities which provide service to the exchange where the communication is originated and the exchange where it is terminated, in lieu of the carrier common line charge, a charge in the amount of $25 per month per circuit that is capable of interconnection. However, if the person provides actual access minutes to the exchange utility, the charge shall be the charge per access minute or fraction thereof provided in 22.14(2)*"d"*(1), not to exceed $25 per line per month. The charge shall apply in all exchanges. However, if the person attests in writing that its facility cannot interconnect and is not interconnected with the exchange in question, the person will not be subject to the charge in that exchange.

(1) In the event that a communication is made without compliance with this rule, the telephone utility or utilities serving the person shall terminate telephone service after notice pursuant to subrule 22.4(5). The utility shall not reinstate service until the board orders the utility to restore service. The board shall order service to be restored when it has reasonable assurance that the person will comply with this rule.

(2) In any action concerning this rule, the burden of proof shall be upon the person making intrastate communications.

(3) This rule shall be inapplicable to:

1. Communications made by a person using facilities or services of telephone utilities to which an intrastate carrier common line charge applies pursuant to 22.14(3)*"a."*

2. Administrative communications made by or to a telephone utility.

22.14(2) *Filing of intrastate access service tariffs.*

a. Tariffs providing for intrastate access services shall be filed with the board by a telephone utility which provides such services. Iowa intrastate access service tariffs of rate-regulated utilities shall be based only on Iowa intrastate costs. Unless otherwise provided, the filings are subject to the applicable rules of the board.

b. A non-rate-regulated local exchange utility in its general tariff may concur in the intrastate access tariff filed by another non-rate-regulated local exchange utility.

(1) Alternatively, a non-rate-regulated local exchange utility may voluntarily elect to join another nonrate regulated local exchange utility or utilities in forming an association of local exchange utilities. The association may file intrastate access service tariffs. A utility in its general tariff can concur in the association tariffs.

(2) All elements of the filings, under rule 199—22.14(476) including access service rate elements, shall be subject to review and approval by the board.

c. Rescinded IAB 2/7/90, effective 3/14/90.

d. All intrastate access service tariffs shall incorporate the following:

(1) Carrier common line charge. The rate for the intrastate carrier common line charge shall be three cents per access minute or fraction thereof for both originating and terminating segments of the communication, unless a different rate is required by numbered paragraphs "1" and "2." The carrier common line charge shall be assessed to exchange access made by any interexchange telephone utility, including resale carriers. In lieu of this charge, interconnected private systems shall pay for access as provided in 22.14(1)*"b."*

1. Incumbent local exchange carrier intrastate access service tariffs shall include the carrier common line charges approved by the board.

2. A competitive local exchange carrier that concurs with the Iowa Telephone Association (ITA) Access Service Tariff No. 1 and that offers service in exchanges where the incumbent local exchange carrier's intrastate access rate is lower than the ITA access rate shall deduct the carrier common line charge from its intrastate access service tariff.

(2) End-user charge. No intrastate end-user charge shall be assessed.

(3) Universal service fund. No universal service fund shall be established.

(4) Transitional and premium rates. There shall be no discounted transitional rate elements applied in Iowa except as otherwise specifically set forth in these rules.

(5) Recording function of billing and collections. The intrastate access service tariffs shall include the rate to be charged for performing the recording function associated with billing and collections.

(6) A telephone utility may, pursuant to tariff, bill for access on the basis of assumed minutes of use where measurement is not practical. However, if the interexchange utility provides actual minutes of use to the billing utility, the actual minutes shall be used.

(7) In the absence of a waiver granted by the board, local exchange utilities shall allow any interexchange utility the option to use its own facilities that were in service on March 19, 1992, to provide local access transport service to terminate its own traffic to the local exchange utility. The interexchange utility may use its facilities in the manner and to a meet point agreed upon by the local exchange utility and the interexchange utility as of March 19, 1992. Changes mutually agreeable to the local exchange utility and the interexchange utility after that date also shall be recognized in allowing the interexchange utility to use its own local access transport facilities to terminate its own traffic. Recognition under this rule will also be extended to improvements by an interexchange utility that provided all the transport facilities to an exchange on March 19, 1992, whether the improvements were mutually agreeable or not, unless the improvements are inconsistent with an agreement between the interexchange utility and the local exchange utility.

(8) A provision prohibiting the application of association access service rates to HVAS traffic.

e. A local exchange utility that is adding a new HVAS customer or otherwise reasonably anticipates an HVAS situation shall provide notice of the situation, the telephone numbers that will be assigned to the HVAS customer (if applicable), and the expected date service to the HVAS customer will be initiated, if applicable. Notice may be sent to each interexchange utility that paid for intrastate access services from the local exchange carrier in the preceding 12 months; to any carrier with whom the local exchange carrier exchanged traffic in the preceding 12 months; and to all other local exchange carriers authorized to provide service in the subject exchange, by a method calculated to provide adequate notice. Any interexchange utility may request negotiations concerning the access rates applicable to calls to or from the HVAS customer.

Any interexchange utility that believes a situation has occurred or is occurring that does not specifically meet the HVAS threshold requirements defined in subrule 22.1(3), but which raises the same general concerns and issues as an HVAS situation, may file a complaint with the board pursuant to these rules.

A local exchange utility that experiences an increase in intrastate access billings that qualifies as an HVAS situation, but did not add a new HVAS customer or otherwise anticipate the situation, shall notify interexchange utilities of the HVAS situation at the earliest reasonable opportunity, as described in the preceding paragraph. Any interexchange utility may request negotiations concerning whether the local exchange utility's access rates, as a whole or for HVAS only, should be changed to reflect the increased access traffic.

When a utility requests negotiations concerning intrastate access services, the parties shall negotiate in good faith to achieve reasonable terms and procedures for the exchange of traffic. No access charges shall apply to the HVAS traffic until an access tariff for HVAS is accepted for filing by the board and has become effective. At any time that any party believes negotiations will not be successful, any party may file a written complaint with the board pursuant to Iowa Code section 476.11. In any such proceeding, the board will consider setting the rate for access services for HVAS traffic based upon the incremental

cost of providing HVAS, although any other relevant evidence may also be considered. The incremental cost will not include marketing or other payments made to HVAS customers. The resulting rates for access services may include a range of rates based upon the volume of access traffic or other relevant factors. Any negotiations pursuant to this paragraph shall conclude within 60 days. After 60 days, a party to the negotiations may petition the board to extend the period of negotiations or may petition the board to set a hearing pursuant to 199—paragraph 7.4(10)*"d."*

22.14(3) Rescinded, IAB 9/21/88, effective 10/26/88.

22.14(4) *Notice of intrastate access service tariffs.*

a. Each telephone utility that files new or changed tariffs relating to access charges, access service, or the recording function associated with billing and collection for access services shall give written notice of the new or changed tariffs to the utility's interexchange utility access customers, the board, and the consumer advocate. Notice shall be given on or before the date of filing of the tariff. The notice shall consist of: the file date, the proposed effective date, a description of the proposed changes, and the tariff section number where the service description is located. If two or more local exchange utilities concur in a single tariff filing, the local exchange utilities may send a joint written notice to the board, consumer advocate, and the interexchange utilities.

b. The board shall not approve any new or changed tariff described in paragraph *"a"* until after the period for resistance provided in subrule 22.14(5), paragraph *"a."*

22.14(5) *Resistance to intrastate access service tariffs.*

a. If an interexchange utility affected by an access service filing or the consumer advocate desires to file a resistance to a proposed new or changed access service tariff, it shall file its resistance within 14 days after the filing of the proposed tariff. The interexchange utility shall send a copy of the resistance to all telephone utilities filing or concurring in the proposed tariff.

b. After receipt of a timely resistance, the board may:

(1) Deny the resistance if it does not on its face present a material issue of adjudicative fact or the board determines the resistance to be frivolous or otherwise without merit and allows the tariff to go into effect by order or by operation of law; or

(2) Either suspend the tariff or allow the tariff to become effective subject to refund; and initiate informal complaint proceedings; or

(3) Either suspend the tariff or allow the tariff to become effective subject to refund; and initiate contested case proceedings; or

(4) Reject the tariff, stating the grounds for rejection.

c. The interexchange utility or the consumer advocate shall have the burden to support its resistance.

d. If contested case proceedings are initiated upon resistance filed by an interexchange utility, the interexchange utility shall pay the expenses reasonably attributable to the proceeding unless the interexchange utility is the successful party as determined by the board.

22.14(6) *Access charge rules to prevail.* The provisions of rule 199—22.14(476) shall be determinative of the procedures relating to intrastate access service tariffs and shall prevail over all inconsistent rules.

[**ARC 7826B**, IAB 6/3/09, effective 7/8/09; **ARC 8871B**, IAB 6/30/10, effective 8/4/10]

199—22.15(476) Interexchange utility service and access.

22.15(1) *Interexchange utility service.* An interexchange utility may provide interexchange service by complying with the laws of this state and the rules of this board. Any company or other entity accessing local exchange facilities or services in order to provide interexchange communication services to the public shall be considered to be an interexchange utility and subject to the rules herein, unless otherwise exempted. Such utilities are required to file a registration form, reports, and other items and are subject to service standards as specified in utilities division rules, unless otherwise exempted.

22.15(2) *Interexchange utility intrastate access.* Intrastate access to local exchange services or facilities may be obtained by an interexchange utility by ordering and paying for such intrastate access

pursuant to the applicable tariff filed by the exchange utility in question, or as otherwise provided by agreement between the parties.

22.15(3) *Willful violation.* Any interexchange utility which the board finds has willfully failed to pay the intrastate carrier common line charge as specified in 22.14(3)*"a"* shall be in willful violation of board rules.

[**ARC 7826B**, IAB 6/3/09, effective 7/8/09]

199—22.16(476) Discontinuance of service. No local exchange utility or interexchange utility may discontinue providing intrastate service to any local exchange or part of a local exchange except in the case of emergency, nonpayment of account, or violation of rules and regulations; except as provided below.

22.16(1) Prior to discontinuing service, the utility shall file with the board and consumer advocate a notice of intent to discontinue service at least 90 days prior to the proposed date of discontinuance. However, if the utility shows it has no customers for the service it proposes to discontinue, the utility need only file such notice 30 days prior to discontinuance.

22.16(2) The notice of discontinuance of service shall include the following:

1. The name and address of the utility involved;
2. The name, title, and address of the person to whom correspondence concerning the notice should be directed;
3. A description of the nature of and reasons for the proposed discontinuance;
4. Identification of the exchange or part of exchange involved and the date on which the utility desires to discontinue service;
5. A description of the area affected and an assessment of the impact on present and future public convenience and necessity of such discontinuance, including the name and address of any other utility currently or potentially providing the same or substitute service to the area;
6. A description of the service proposed to be discontinued, of the existing service available to the exchange or part of exchange involved, and of the service of the applying utility or others which would remain in the event approval is granted.

22.16(3) If after 30 days of the filing of such notice, no action is taken by the board, the discontinuance may take place as proposed.

22.16(4) The board, on its own motion or at the request of the consumer advocate or affected customer, may hold a hearing on such discontinuance.

199—22.17(476) Resale of service.

22.17(1) Any landlord, owner, tenant association, or otherwise affiliated group shall be permitted to provide communications services within or between one or more buildings with a community of interest. The provision of this service will be treated as a deregulated service, if the following requirements are met:

a. No person within a building or facility providing resale services shall be denied access to the local exchange carrier. The local exchange carrier shall provide service at normal tariffed rates to the point of demarcation. The end-user shall be responsible for service beyond that point. However, no person shall unreasonably inhibit the end-user's access to the local exchange carrier.

b. Telephone rates charged to resale providers of communications services under this rule shall be made on the same basis as business service.

c. "Community of interest" will normally be indicated by joint or common ownership, but any other relevant factors may be considered.

22.17(2) Any interested person may request formal complaint proceedings with respect to any existing or proposed resale arrangement under this rule. Complaints may concern, but are not limited to:

a. Whether the reseller is, in fact, a local exchange carrier in its own right, as demonstrated by limitations on access to the original local exchange carrier, the geographical area of the offering, or other relevant factors; and

b. Whether the reseller is allowing access to the local exchange carrier on reasonable terms.

199—22.18(476) Low-income connection assistance program. Rescinded IAB 12/31/97, effective 1/1/98.

199—22.19(476) Alternative operator services.

22.19(1) *Definitions.* The definitions found in Iowa Code section 476.91 apply to this rule.

22.19(2) *Tariffs.* Alternative operator service companies must provide service pursuant to board-approved tariffs covering both rates and service.

22.19(3) *Blocking.* AOS companies shall not block the completion of calls which would allow the caller to reach a long distance telephone company different from the AOS company. All AOS company contracts with contracting entities must prohibit call blocking by the contracting entity. The contracting entity shall not violate that contract provision.

22.19(4) *Posting.* Contracting entities must post on or in close proximity to all telephones served by an AOS company the following information:

a. The name and address of the AOS company;

b. A customer service number for receipt of further service and billing information; and

c. Dialing directions to the AOS operator for specific rate information.

Contracts between AOS companies and contracting entities shall contain provisions for posting the information. The AOS companies also are responsible for the form of the posting and shall make reasonable efforts to ensure implementation, both initially and on an updated basis.

22.19(5) *Oral identification.* All AOS companies shall announce to the end-user customer the name of the provider carrying the call and shall include a sufficient delay period to permit the caller to terminate the call or advise the operator to transfer the call to the end-user customer's preferred carrier before billing begins.

22.19(6) *Billing.* All AOS company bills to end-user customers shall comply with the following requirements, in addition to the requirements of subrule 22.4(3):

a. All calls, except those billed to commercial credit cards, shall be itemized and identified separately on the bill. All calls will be rated solely from the end-user customer's point of origin to point of termination.

b. All bills, except those for calls billed to commercial credit cards, shall be rendered within 60 days of the provision of the service.

c. All charges for the use of a telephone instrument shall be shown separately for each call, except for calls billed to a commercial credit card.

22.19(7) *Emergency calls.* All AOS companies shall have a board-approved methodology to ensure the routing of all emergency zero-minus (0 -) calls in the fastest possible way to the proper local emergency service agency.

199—22.20(476) Service territories. Service territories are defined by the telephone exchange area boundary maps on file with the Iowa utilities board. The maps will be available for viewing at the board's office during regular business hours and copies are available at the cost of reproduction. This rule does not apply to resale of local telephone service pursuant to rule 199—22.17(476).

22.20(1) *Issuance of certificates of authority to utilities on or prior to September 30, 1992.* The initial nonexclusive certificate of authority will be issued by the board on or before September 30, 1992, to each land-line telephone utility providing local telecommunications service in Iowa. The certificate will authorize service within the territory as shown by boundary maps in effect on January 1, 1992, but will reference and include modifications approved by the board prior to the issuance of the certificate. The certificate will be in the form of an order issued by the board and may be modified only by subsequent board orders.

If a utility disputes the boundary identified in the January 1, 1992, maps or in a certificate, it may file an objection with the board. After notice to interested persons and an opportunity for hearing, the board will determine the boundary.

22.20(2) *Procedures to revise maps and modify certificates.* All territory in the state shall be served by a local exchange utility and inappropriate overlaps of service territories are to be avoided.

a. When the board, after informal investigation, determines a significant gap or overlap exists on the maps on file defining service territories, affected utilities and interested persons, including affected customers, will be notified. The board will direct the affected utilities to file a proposed boundary within 30 days, if the utilities can agree.

b. The boundary filing must include the name of each affected customer and justification for the proposed boundary, including a detailed statement of why the proposal is in the public interest. Prior to filing with the board, the serving utilities must notify interested persons of a convenient location where they can view the current and proposed maps, or copies of the maps covering their location must be mailed to them. The notice shall state the nature of the boundary filing and that any objections must be mailed to the board postmarked within 14 days of the mailing of the notice by the utility. The utility's filing shall also include a copy of the notice and the date on which the notice was mailed to customers.

c. Upon board approval of the proposed boundary, the affected utilities shall file revised maps which comply with subrule 22.20(3) and, upon approval of the maps, the board will modify the certificates.

d. If the utilities cannot agree on the boundary, or if an interested person timely mails material objections to the proposed boundary, the board will resolve the issues in contested case proceedings to revise the maps and modify the certificates after notice of the proceedings to all affected utilities and interested persons.

e. A voluntary modification petition filed jointly by all affected utilities pursuant to 1992 Iowa Acts, Senate File 511, shall contain the information required in 22.20(2)*"b."* The notice and hearing requirements in 22.20(2)*"b"* through *"d"* shall be observed in voluntary modification proceedings.

f. A post-January 1, 1992, map will not be effective in defining a utility's service territory until approved by the board.

22.20(3) *Map specifications.* All ILECs shall have on file with the board maps which identify their exchanges and both internal exchange boundaries where the utility's own exchanges abut and ultimate boundaries where the utility's exchanges abut other utilities. A CLEC shall either file its own exchange boundary map or adopt the exchange boundary map filed by the ILEC serving that exchange.

a. Each utility's maps shall be on a scale of one inch to the mile. They shall include information equivalent to the county maps which are available from the Iowa department of transportation, showing all roads, railroads, waterways, plus township and range lines outside the municipalities. A larger scale shall be used where necessary to clarify areas. All map details shall be clean-cut and readable.

(1) Each filed map shall clearly show the ultimate utility boundary line; this line shall be periodically marked with the letter "U." Exchange boundaries where the utility's own exchanges abut shall be periodically marked with the letter "E." Ultimate and exchange boundary lines shall be drawn on a section, half-section, or quarter-section line. If not, the distance from a section line or other fixed reference point shall be clearly noted. When using a fixed reference point, measurement shall always be from the center of the fixed point.

(2) The map shall also identify the utility serving each contiguous exchange. The utility names shall be placed about the exterior of the ultimate boundary. The points at which the adjacent exchange meets the ultimate boundary will be marked with arrows.

(3) Plant facilities shall not be shown on the boundary map. Approximate service locations may be shown but are not required.

(4) The name of the utility filing the map shall be placed in the upper right corner of the map. This will be followed by the names of each exchange shown on the map and served by that utility. The last item will be the date the map is filed and the proposed effective date, which will be 30 days after the filing date unless the board sets a different date.

b. If requested by the board, a legal description shall be filed to clarify an ambiguous boundary between utilities. The legal description shall conform with the standards set in Iowa Code section 114A.9.

22.20(4) *Subsequent certificates.* Any legal entity which desires to serve all or a portion of a territory which is currently assigned to another land-line utility may petition for a new certificate or a certificate modification depending upon whether the utility already has a certificate to serve. After notice to affected utilities and opportunity for hearing, the board will determine whether the new certificate or certificate

modification will promote the public convenience and necessity. If the new or modified certificate is granted, the result may be two or more utilities serving all or a portion of an assigned territory.

22.20(5) *Certificate revocation.* Any five subscribers or potential subscribers, an interexchange utility, or consumer advocate upon filing a sworn statement showing a generalized pattern of inadequate telephone service or facilities may petition the board to begin formal certificate revocation proceedings against a local exchange utility. For the purposes of this rule, inadequate telephone service or facilities may include the failure to bill high-volume intrastate access (HVAS) charges in a manner consistent with the requirements of rule 199—22.14(476). While similar in nature to a complaint filed under rule 199—6.2(476), a petition under this rule shall be addressed by the board under the following procedure and not the procedure found in 199—Chapter 6.

a. Upon receiving a petition, the board will make an informal preliminary investigation into the adequacy of the service and facilities provided by a local exchange utility. The board also may begin an informal preliminary investigation on its own motion at any time.

b. Prior to beginning formal revocation proceedings under 1992 Iowa Acts, Senate File 511, the board will provide notice to the utility of any alleged inadequacies in its service. The utility may admit or deny the allegations. If admitted, the utility will have a reasonable time to eliminate the inadequacies. If denied, the utility will have the opportunity to refute the allegations in contested case proceedings after mailed notice and an opportunity to intervene for the utility's affected customers.

c. If the board does not issue the notice of alleged inadequacies to the utility as provided in 22.20(2)*"b"* within 60 days after the filing of the petition, the petition will be deemed denied.

d. If the board finds significant inadequacies in service or facilities in any certificate revocation contested case, the utility will be allowed a reasonable time to eliminate the inadequacies.

e. If the utility fails to eliminate significant inadequacies in service or facilities within a reasonable time, the board, after mailed notice to all parties in the contested case, or to affected customers if the utility admitted the inadequacies, and after an opportunity for hearing, may revoke or condition the certificate as provided in 1992 Iowa Acts, Senate File 511.

f. Proceedings under this subrule may be combined with proceedings under subrule 22.20(4), or similar certification proceedings initiated on the board's own motion, to consider an appropriate replacement utility simultaneously with the revocation case.

[**ARC 7826B**, IAB 6/3/09, effective 7/8/09; **ARC 8871B**, IAB 6/30/10, effective 8/4/10]

199—22.21(476) Toll dialing patterns. All local exchange utilities shall use the dialing pattern, 0 or 1 plus ten digits, for all toll calls either within a single numbering plan area or from one numbering plan area to another.

199—22.22(476) Requests for interconnection negotiations. Rescinded IAB 8/28/96, effective 8/2/96.

199—22.23(476) Unauthorized changes in telephone service.

22.23(1) *Definitions.* As used in this rule, unless the context otherwise requires:

"Change in service" means the designation of a new provider of a telecommunications service to a customer, including the initial selection of a service provider, and includes the addition or deletion of a telecommunications service for which a separate charge is made to a customer account.

"Consumer" means a person other than a service provider who uses a telecommunications service.

"Cramming" means the addition or deletion of a product or service for which a separate charge is made to a telecommunication customer's account without the verified consent of the affected customer. Cramming does not include the addition of extended area service to a customer account pursuant to board rules, even if an additional charge is made. Cramming does not include telecommunications services that are initiated or requested by the customer, including dial-around services such as "10-10-XXX," directory assistance, operator-assisted calls, acceptance of collect calls, and other casual calling by the customer.

"Customer" means the person other than a service provider whose name appears on the account and others authorized by that named person to make changes to the account.

"Executing service provider" means, with respect to any change in telecommunications service, a service provider who executes an order for a change in service received from another service provider or from its own customer.

"Jamming" means the addition of a preferred carrier freeze to a customer's account without the verified consent of the customer.

"Letter of agency" means a written document complying with the requirements of 199 IAC 22.23(2)*"b."*

"Preferred carrier freeze" means the limitation of a customer's preferred carrier choices so as to prevent any change in preferred service provider for one or more services unless the customer gives the service provider from which the freeze was requested the customer's express consent.

"Service provider" means a person providing a telecommunications service, not including commercial mobile radio service.

"Slamming" means the designation of a new provider of a telecommunications service to a customer, including the initial selection of a service provider, without the verified consent of the customer. "Slamming" does not include the designation of a new provider of a telecommunications service to a customer made pursuant to the sale or transfer of another carrier's customer base, provided that the designation meets the requirements of 199 IAC 22.23(2)*"e."*

"Soft slam" means an unauthorized change in service by a service provider that uses the carrier identification code (CIC) of another service provider, typically through the purchase of wholesale services for resale.

"Submitting service provider" means a service provider who requests another service provider to execute a change in service.

"Telecommunications service" means a local exchange or long distance telephone service other than commercial mobile radio service.

"Verified consent" means verification of a customer's authorization for a change in service.

22.23(2) *Prohibition of unauthorized changes in telecommunications service.* Unauthorized changes in telecommunications service, including but not limited to cramming and slamming, are prohibited.

a. Verification required. No service provider shall submit a preferred carrier change order or other change in service order to another service provider unless and until the change has first been confirmed in accordance with one of the following procedures:

(1) The service provider has obtained the customer's written authorization in a form that meets the requirements of 199 IAC 22.23(2)*"b"*; or

(2) The service provider has obtained the customer's electronic authorization to submit the preferred carrier change order. Such authorization must be placed from the telephone number(s) on which the preferred carrier is to be changed and must confirm the information required in subparagraph (1) above. Service providers electing to confirm sales electronically shall establish one or more toll-free telephone numbers exclusively for that purpose. Calls to the number(s) will connect a customer to a voice response unit, or similar mechanism that records the required information regarding the preferred carrier change, including automatically recording the originating automatic numbering identification; or

(3) An appropriately qualified independent third party has obtained the customer's oral authorization to submit the preferred carrier change order that confirms and includes appropriate verification data. The independent third party must not be owned, managed, controlled, or directed by the service provider or the service provider's marketing agent; must not have any financial incentive to confirm preferred carrier change orders for the service provider or the service provider's marketing agent; and must operate in a location physically separate from the service provider or the service provider's marketing agent. The content of the verification must include clear and conspicuous confirmation that the customer has authorized a preferred carrier change; or

(4) The local service provider may change the preferred service provider, for customer-originated changes to existing accounts only, through maintenance of sufficient internal records to establish a valid customer request for the change in service. At a minimum, any such internal records must include the date and time of the customer's request and adequate verification of the identification of the person

requesting the change in service. The burden will be on the telecommunications carrier to show that its internal records are adequate to verify the customer's request for the change in service.

All verifications shall be maintained for at least two years from the date the change in service is implemented. Verification of service freezes shall be maintained for as long as the preferred carrier freeze is in effect.

(5) For other changes in service resulting in additional charges to existing accounts only, a service provider shall establish a valid customer request for the change in service through maintenance of sufficient internal records. At a minimum, any such internal records must include the date and time of the customer's request and adequate verification under the circumstances of the identification of the person requesting the change in service. Any of the three verification methods in 22.23(2)*"a"*(1) to (3) will also be acceptable. The burden will be on the telecommunications carrier to show that its internal records are adequate to verify the customer's request for the change in service. Where the additional charge is for one or more specific telephone calls, examples of internal records a carrier may submit include call records showing the origin, date, time, destination, and duration of the calls, and any other data the carrier relies on to show the calls were made or accepted by the customer, along with an explanation of the records and data.

b. Letter of agency form and content.

(1) A service provider may use a letter of agency to obtain written authorization or verification of a customer's request to change the customer's preferred service provider selection. A letter of agency that does not conform with this subrule is invalid for purposes of this rule.

(2) The letter of agency shall be a separate document (or an easily separable document) containing only the authorizing language described in subparagraph (5) below having the sole purpose of authorizing a service provider to initiate a preferred service provider change. The letter of agency must be signed and dated by the customer to the telephone line(s) requesting the preferred service provider change.

(3) The letter of agency shall not be combined on the same document with inducements of any kind.

(4) Notwithstanding subparagraphs (2) and (3) above, the letter of agency may be combined with checks that contain only the required letter of agency language as prescribed in subparagraph (5) below and the necessary information to make the check a negotiable instrument. The letter of agency check shall not contain any promotional language or material. The letter of agency check shall contain, in easily readable, boldface type on the front of the check, a notice that the customer is authorizing a preferred service provider change by signing the check. The letter of agency language shall be placed near the signature line on the back of the check.

(5) At a minimum, the letter of agency must be printed with a type of sufficient size and readable type to be clearly legible and must contain clear and unambiguous language that confirms:

1. The customer's billing name and address and each telephone number to be covered by the preferred service provider change order;

2. The decision to change the preferred service provider from the current service provider to the soliciting service provider;

3. That the customer designates [insert the name of the submitting service provider] to act as the customer's agent for the preferred service provider change;

4. That the customer understands that only one service provider may be designated as the customer's interstate or interLATA preferred interexchange service provider for any one telephone number. To the extent that a jurisdiction allows the selection of additional preferred service providers (e.g., local exchange, intraLATA/intrastate toll, interLATA/interstate toll, or international interexchange), the letter of agency must contain separate statements regarding those choices, although a separate letter of agency for each choice is not necessary; and

5. That the customer understands that any preferred service provider selection the customer chooses may involve a charge to the customer for changing the customer's preferred service provider.

(6) Any service provider designated in a letter of agency as a preferred service provider must be the service provider directly setting the rates for the customer.

(7) Letters of agency shall not suggest or require that a customer take some action in order to retain the customer's current service provider.

(8) If any portion of a letter of agency is translated into another language, then all portions of the letter of agency must be translated into that language. Every letter of agency must be translated into the same language as any promotional materials, oral descriptions or instructions provided with the letter of agency.

c. Customer notification. Every change in service shall be followed by a written notification to the affected customer to inform the customer of the change. Such notice shall be provided within 30 days of the effective date of the change. Such notice may include, but is not limited to, a conspicuous written statement on the customer's bill, a separate mailing to the customer's billing address, or a separate written statement included with the customer's bill. Each such statement shall clearly and conspicuously identify the change in service, any associated charges or fees, the name of the service provider associated with the change, and a toll-free number by which the customer may inquire about or dispute any provision in the statement.

d. Preferred carrier freezes.

(1) A preferred service provider freeze (or freeze) prevents a change in a customer's preferred service provider selection unless the customer gives the service provider from whom the freeze was requested express consent. All local exchange service providers who offer preferred service provider freezes must comply with the provisions of this subrule.

(2) All local exchange service providers who offer preferred service provider freezes shall offer freezes on a nondiscriminatory basis to all customers, regardless of the customer's service provider selections.

(3) Preferred service provider freeze procedures, including any solicitation, must clearly distinguish among telecommunications services (e.g., local exchange, intraLATA/intrastate toll, interLATA/interstate toll, and international toll) subject to a preferred service provider freeze. The service provider offering the freeze must obtain separate authorization for each service for which a preferred service provider freeze is requested.

(4) Solicitation and imposition of preferred service provider freezes.

1. All solicitation and other materials provided by a service provider regarding preferred service provider freezes must include:

- An explanation, in clear and neutral language, of what a preferred service provider freeze is and what services may be subject to a freeze;
- A description of the specific procedures necessary to lift a preferred service provider freeze; an explanation that these steps are in addition to the verification requirements in 22.23(2)*"a"* and 22.23(2)*"b"* for changing a customer's preferred service provider selections; and an explanation that the customer will be unable to make a change in service provider selection unless the freeze is lifted; and
- An explanation of any charges associated with the preferred carrier freeze.

2. No local exchange carrier shall implement a preferred service provider freeze unless the customer's request to impose a freeze has first been confirmed in accordance with one of the following procedures:

- The local exchange carrier has obtained the customer's written and signed authorization in a form that meets the requirements of 22.23(2)*"d"*(4)"3"; or
- The local exchange carrier has obtained the customer's electronic authorization, placed from the telephone number(s) on which the preferred service provider freeze is to be imposed, to impose a preferred service provider freeze. The electronic authorization shall confirm appropriate verification data and the information required in 22.23(2)*"d"*(4)"3." Service providers electing to confirm preferred service provider freeze orders electronically shall establish one or more toll-free telephone numbers exclusively for that purpose. Calls to the number(s) will connect a customer to a voice response unit, or similar mechanism that records the required information regarding the preferred service provider freeze request, including automatically recording the originating automatic numbering identification; or
- An appropriately qualified independent third party has obtained the customer's oral authorization to submit the preferred service provider freeze and confirmed the appropriate verification

data and the information required in 22.23(2)*"d"*(4)"3." The independent third party must not be owned, managed, or directly controlled by the service provider or the service provider's marketing agent; must not have any financial incentive to confirm preferred service provider freeze requests for the service provider or the service provider's marketing agent; and must operate in a location physically separate from the service provider or the service provider's marketing agent. The content of the verification must include clear and conspicuous confirmation that the customer has authorized a preferred service provider freeze.

3. A local exchange service provider may accept a written and signed authorization to impose a freeze on the customer's preferred service provider selection. Written authorization that does not conform with this subrule is invalid and may not be used to impose a preferred service provider freeze.

- The written authorization shall comply with 22.23(2)*"b"*(5)"2" and "3" and 22.23(2)*"b"*(8) concerning the form and content for letters of agency.
- At a minimum, the written authorization must be printed with a readable type of sufficient size to be clearly legible and must contain clear and unambiguous language that confirms: (1) the customer's billing name and address and the telephone number(s) to be covered by the preferred service provider freeze; (2) the decision to place a preferred service provider freeze on the telephone number(s) and particular service(s). To the extent that a jurisdiction allows the imposition of preferred service provider freezes on additional preferred service provider selections (e.g., for local exchange, intraLATA/intrastate toll, interLATA/interstate toll service, and international toll), the authorization must contain separate statements regarding the particular selections to be frozen; (3) that the customer understands that the customer will be unable to make a change in service provider selection unless the preferred service provider freeze is lifted; and (4) that the customer understands that any preferred carrier freeze may involve a charge to the customer.

(5) All local exchange service providers who offer preferred service provider freezes must, at a minimum, offer customers the following procedures for lifting a preferred service provider freeze:

1. A local exchange service provider administering a preferred service provider freeze must accept a customer's written and signed authorization stating the intention to lift a preferred service provider freeze; and

2. A local exchange service provider administering a preferred service provider freeze must accept a customer's oral authorization stating the intention to lift a preferred carrier freeze and must offer a mechanism that allows a submitting service provider to conduct a three-way conference call with the service provider administering the freeze and the customer in order to lift a freeze. When engaged in oral authorization to lift a preferred service provider freeze, the service provider administering the freeze shall confirm appropriate verification data and the customer's intent to lift the particular freeze.

e. Procedures in the event of sale or transfer of customer base. A telecommunications carrier may acquire, through a sale or transfer, either part or all of another telecommunications carrier's customer base without obtaining each customer's authorization in accordance with 199 IAC 22.23(2)*"a,"* provided that the acquiring carrier complies with the following procedures. A telecommunications carrier may not use these procedures for any fraudulent purpose, including any attempt to avoid liability for violations under 199 IAC 22.23(2)*"a."*

(1) No later than 30 days before the planned transfer of the affected customers from the selling or transferring carrier to the acquiring carrier, the acquiring carrier shall file with the board a letter notifying the board of the transfer and providing the names of the parties to the transaction, the types of telecommunications services to be provided to the affected customers, and the date of the transfer of the customer base to the acquiring carrier. In the letter, the acquiring carrier also shall certify compliance with the requirement to provide advance customer notice in accordance with 199 IAC 22.23(2)*"e"*(3) and with the obligations specified in that notice. In addition, the acquiring carrier shall attach a copy of the notice sent to the affected customers.

(2) If, subsequent to the filing of the letter of notification with the board required by 199 IAC 22.23(2)*"e"*(1), any material changes to the required information develop, the acquiring carrier shall file written notification of these changes with the board no more than 10 days after the transfer date

announced in the prior notification. The board may require the acquiring carrier to send an additional notice to the affected customers regarding such material changes.

(3) Not later than 30 days before the transfer of the affected customers from the selling or transferring carrier to the acquiring carrier, the acquiring carrier shall provide written notice to each affected customer. The acquiring carrier must fulfill the obligations set forth in the written notice. The written notice must inform the customer of the following:

1. The date on which the acquiring carrier will become the customer's new provider of telecommunications service;

2. The rates, terms, and conditions of the service(s) to be provided by the acquiring carrier upon the customer's transfer to the acquiring carrier, and the means by which the acquiring carrier will notify the customer of any change(s) to these rates, terms, and conditions;

3. The acquiring carrier will be responsible for any carrier change charges associated with the transfer;

4. The customer's right to select a different preferred carrier for the telecommunications service(s) at issue, if an alternative carrier is available;

5. All customers receiving the notice, even those who have arranged preferred carrier freezes through their local service providers on the service(s) involved in the transfer, will be transferred to the acquiring carrier unless they have selected a different carrier before the transfer date; existing preferred carrier freezes on the service(s) involved in the transfer will be lifted; and the customers must contact their local service providers to arrange a new freeze;

6. Whether the acquiring carrier will be responsible for handling any complaints filed, or otherwise raised, prior to or during the transfer against the selling or transferring carrier; and

7. The toll-free customer service telephone number of the acquiring carrier.

22.23(3) *Carrier registration.*

a. Registration required. Each carrier that provides or bills for telecommunications services to customers located in Iowa shall register with the board and shall provide, at a minimum, the information specified in the form that appears in this subrule.

DEPARTMENT OF COMMERCE

UTILITIES BOARD

TELECOMMUNICATIONS SERVICE PROVIDER REGISTRATION

1. FULL NAME OF CARRIER PROVIDING SERVICE IN IOWA:

_____

2. CARRIER MAILING ADDRESS (including 9-digit ZIP code):

_____

_____

_____

3. NAME, TITLE, TELEPHONE NUMBER, E-MAIL ADDRESS, AND FAX NUMBER OF CONTACT PERSON:

_____

_____

_____

_____

4. ALL TRADE NAMES OR D/B/A'S USED BY CARRIER IN IOWA OR IN ADVERTISING OR BILLING THAT MAY REACH IOWA CUSTOMERS:

_____

_____

5. NAME, MAILING ADDRESS, AND TELEPHONE NUMBER OF AGENT IN IOWA AUTHORIZED TO ACCEPT SERVICE OF PROCESS ON BEHALF OF CARRIER:

_____

_____

_____

6. TYPES OF TELECOMMUNICATIONS SERVICE PROVIDED (CHECK ALL THAT APPLY):
____ LOCAL EXCHANGE SERVICE
____ INTEREXCHANGE SERVICE
____ DATA TRANSMISSION
____ ALTERNATIVE OPERATOR SERVICES ONLY
____ OTHER—PLEASE SPECIFY:_____
7. ATTESTATION. I, _____, certify that I am the company officer responsible for this registration, that I have examined the foregoing registration, and that to the best of my knowledge, information, and belief the information is accurate and will be updated as required.
Dated ____/____/____
SIGNATURE_____

b. Failure to register. Failure to file and reasonably update a registration, or provision of false, misleading, or incomplete information, may result in civil penalties under 22.23(5) and may be considered as evidence of a pattern or practice of violation of these rules.

22.23(4) *Subscriber complaints regarding changes in service—procedures.* When a telecommunications service provider is contacted by an Iowa customer alleging an unauthorized change in service, the service provider shall inform the customer of the customer's right to contact the board regarding the complaint. The service provider shall provide the customer with the board's toll-free number for complaints, (877)565-4450.

When a subscriber submits to the board a written complaint alleging an unauthorized change in service, the complaint will be processed by the board pursuant to 199—Chapter 6, "Complaint Procedures."

22.23(5) *Civil penalties and assessment of damages.*

a. Civil penalties. In addition to any applicable civil penalty set out in Iowa Code section 476.51, a service provider who violates a provision of the anti-slamming statute, a rule adopted pursuant to the anti-slamming statute, or an order lawfully issued by the board pursuant to the anti-slamming statute is subject to a civil penalty, which, after notice and opportunity for hearing, may be levied by the board, of not more than $10,000 per violation. Each violation is a separate offense.

b. Amount. A civil penalty may be compromised by the board. In determining the amount of the penalty, or the amount agreed upon in a compromise, the board may consider the size of the service provider, the gravity of the violation, any history of prior violations by the service provider, remedial actions taken by the service provider, the nature of the conduct of the service provider, and any other relevant factors.

c. Collection. A civil penalty collected pursuant to this subrule shall be forwarded by the executive secretary of the board to the treasurer of state to be credited to the general fund of the state and to be used only for consumer education programs administered by the board.

d. Exclusion from regulated rates. A penalty paid by a rate-of-return regulated utility pursuant to this subrule shall be excluded from the utility's costs when determining the utility's revenue requirement and shall not be included either directly or indirectly in the utility's rates or charges to its customers.

e. Civil actions. The board shall not commence an administrative proceeding to impose a civil penalty under this rule for acts subject to a civil enforcement action pending in court under Iowa Code section 714D.7.

f. Assessment of damages among interested persons. As a part of formal complaint proceedings, the board may determine the potential liability, including assessment of damages, for unauthorized changes in service among the customer, the previous service provider, the executing service provider, the submitting service provider, and any other interested persons. In the event of a soft slam, the board may impose joint and several liability on the reseller and the facilities-based service provider. For purposes of this rule and in the absence of unusual circumstances, the term "damages" means charges directly relating to the telecommunications services provided to the customer that have appeared or may appear on the customer's bill. The term "damages" does not include incidental, consequential, or punitive damages.

22.23(6) *Penalties for patterns of violations.* If the board determines, after notice and opportunity for hearing, that a service provider has shown a pattern of violations of these rules, the board may by order do any of the following:

a. Prohibit any other service provider from billing charges to residents of Iowa on behalf of the service provider determined to have engaged in such a pattern of violations.

b. Prohibit certificated local exchange service providers from providing exchange access services to the service provider.

c. Limit the billing or access services prohibition under paragraph *"a"* or *"b"* above to a period of time. Such prohibition may be withdrawn upon a showing of good cause.

d. Revoke the certificate of public convenience and necessity of a local exchange service provider.

22.23(7) *Service provider complaints regarding changes in service.* When a service provider files a written complaint charging another service provider with causing unauthorized changes in end user services to the detriment of the complaining service provider, the complaint will be processed pursuant to 199—Chapter 6, "Complaint Procedures," except that any party to the proceeding may petition the board for an order initiating formal complaint proceedings at any time, regardless of the status of the informal complaint proceedings. The board will grant such petitions or enter such an order on its own motion if the board finds that informal complaint proceedings are unlikely to aid in the resolution of the complaint.

199—22.24(476) Applications for numbering resources.

22.24(1) *Application to be filed with the board.* Any communications service provider, including but not limited to local exchange carriers, wireless service providers, and paging companies, applying for numbering resources with the North American Numbering Plan Administrator (NANPA) or the Pooling Administrator (PA) shall send a draft application or executed application to the board by facsimile transfer or electronic mail at least two days prior to the date on which the original application is to be received by the NANPA or PA. A draft application shall contain substantially the same information that is to be contained in an executed application. The application may be faxed to (515)725-7399 or E-mailed to customer@iub.iowa.gov. Electronic submissions shall include "NANPA Application" or "PA Application" in the subject line.

22.24(2) *Confidential treatment.* The information contained in the draft applications or executed applications for numbering resources shall be held as confidential for a period of 90 days or until the new codes are entered into the local exchange routing guide (LERG), whichever is later.

22.24(3) *Content.* Each application filed with the board under this rule shall include a reference to this rule and sufficient information to identify the service provider and a contact person.

[Editorial change: IAC Supplement 12/29/10]

These rules are intended to implement Iowa Code sections 476.1 to 476.3, 476.5, 476.6, 476.8, 476.9, 476.29, 476.91, and 546.7 and Iowa Code Supplement section 476.103.

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◊ Two or more ARCs

1 Effective date of 12/1/83 of subrules 22.1(3), 22.2(5)*"v,"* and 22.3(13) delayed 70 days by the Administrative Rules Review Committee on 11/8/83.

2 Effective date of 22.10(1)*"c"* delayed 70 days by the Administrative Rules Review Committee on 11/14/90; delay lifted 12/11/90, effective 12/12/90.

3 Effective date of 22.4(2)*"b"* delayed until the adjournment of the 1994 Session of the General Assembly pursuant to Iowa Code section 17A.8(9) by the Administrative Rules Review Committee at its meeting held September 15, 1993.

CHAPTER 24
LOCATION AND CONSTRUCTION OF ELECTRIC POWER GENERATING FACILITIES

[Prior to 10/8/86, Commerce Commission[250]]

199—24.1(476A) Authority, purpose, and policy.

24.1(1) *Authority.* The regulations contained herein are prescribed by the Iowa utilities board pursuant to authority granted the board in Iowa Code chapter 476A, relating to the location and construction of electric power generating facilities.

24.1(2) *Purpose.* The purpose of these regulations is to provide guidelines for proceedings for the determination whether the proposed construction of a major electric generation facility or significant alteration thereto should be issued a certificate before such construction may commence and to state the procedures for determining compliance by the applicant with permit and licensing requirements of state regulatory agencies.

24.1(3) *Cooperative agreements.* The board may enter into cooperative agreements pursuant to Iowa Code chapter 28E with the appropriate state agencies that will facilitate thorough review of all state issues arising in the certification process and will reduce the time and expense in determining, to the extent necessary, the environmental, economic, and social effects of the facility's construction and use. Under the auspices of these 28E agreements, the board shall delegate to the various state agencies responsibility for the issuance of permits and licenses appropriate to the authority of the agency to ensure compliance with the steps in the certification process. The board, where appropriate, may use a consolidated hearing process.

199—24.2(476A) Definitions. As used in this chapter:

"Acid Rain Program" means the sulfur dioxide and nitrogen oxides air pollution control program established pursuant to Title IV of the Clean Air Act, 42 U.S.C. Section 7401, et seq., as amended by Pub. L. 101-549, November 15, 1990.

"Act" means Iowa Code chapter 476A entitled Electric Power Generators.

"Agency" means an agency as defined in Iowa Code section 17A.2(1).

"Allowance" means an authorization, allocated by the federal Environmental Protection Agency under the Acid Rain Program, to emit up to one ton of sulfur dioxide, during or after a specified calendar year.

"Applicant" means the person or persons who make an application for a certificate for a facility or an amendment to a certificate for a facility under the Act. For projects with more than one participant, the applicant may be that person designated by and acting on behalf of the participants.

"Application" means an application for a certificate or an amendment to a certificate submitted to the board pursuant to the Act.

"Board" means the utilities board.

"Certificate" means a certificate as defined in Iowa Code section 476A.1.

"Contested case proceeding" means the contested case proceeding before the board prescribed by Iowa Code section 476A.4.

"Facility" means any electric power generating plant or combination of plants at a single site, owned by any person, with a maximum generator nameplate capacity of 25 megawatts of electricity or more and those associated transmission lines connecting the generating plant to either a power transmission system or an interconnected primary transmission system or both. This term includes any generation addition that increases the total maximum generator nameplate capacity at one site to 25 megawatts or more, but does not include those transmission lines beyond the generation station's substation.

"Interested agency" means an agency, other than a regulatory agency, which the board in its discretion determines to have a legitimate interest in the disposition of the application.

"Intervenor" means a person who received notice under 24.6(2)*"b," "c," "d," "e,"* or *"f"* and has filed with the board a written notice of intervention, or, in all other cases, who, upon written petition of intervention is permitted in the proceeding pursuant to 199—subrule 7.2(8).

"Participant" means any person who either jointly or severally owns or operates a proposed facility or significant alteration thereto or who has contracted or intends to contract for a purchase of electricity produced by the subject facility.

"Party" means each person or agency named or admitted as a party, including the applicant, intervenors, and consumer advocate.

"Person" means individual, corporation, cooperative, government or governmental subdivision or agency, partnership, association or other legal entity.

"Public utility" means a public utility as defined in Iowa Code section 476.1.

"Regulatory agency" means a state agency which issues licenses or permits required for the construction, operation or maintenance of a facility pursuant to statutes or rules in effect on the date on which an application for a certificate is accepted by the board.

"Significant alteration" means:

a. A change in the generic type of fuel used by the major electric generating facility; or

b. Any change in the location, construction, maintenance, or operation of equipment at an existing facility that results in a 10 percent increase or more in the maximum generator nameplate capacity of an existing facility if the increase is more than or equal to 25 megawatts.

"Site" means the land on which the generating unit of the facility, and any cooling facilities, cooling water reservoirs, security exclusion areas, and other necessary components of the facility, are proposed to be located.

"Site impact area" means the area within the state of Iowa within a ten-mile radius of the intersection of the transverse centerline axis and longitudinal centerline axis of the generator or all such generators where the proposed facility includes multiple generators.

"Zoning authority" means any city or county zoning authority in whose jurisdictional area a proposed facility site or portion thereof is located.

199—24.3(476A) Form of application, place of filing.

24.3(1) *Form of application.*

a. The application, associated documents, or other papers filed with the board in a certification proceeding shall be printed or typewritten and reproduced on sheets of 8½ inches by 11 inches (except for foldouts and special exhibits) in loose leaf or equivalent replaceable sheet form with hard cover.

b. The information required by these rules shall be indexed and arranged in a sequential manner substantially similar to the outline form of the rules, with all material submitted categorized into the specific areas and sections set forth in the rules.

24.3(2) *Manner and place of filing.*

a. An applicant shall file the original and 20 copies of its application with the board by presentation or mailing to the Executive Secretary, Iowa Utilities Board, 1375 E. Court Avenue, Room 69, Des Moines, Iowa 50319-0069.

b. Within ten days of receipt of the application the Executive Secretary shall acknowledge in writing receipt of the application, but said acknowledgment shall not constitute acceptance of the application.

c. Within ten days of the receipt of application, the board shall forward copies thereof to each regulatory agency listed in the application. In addition, that part of the application responding to 24.4(1)*"a"* through *"c"* will be forwarded to such other agencies as the board deems appropriate, including the office of state archaeologist, the division of community action agencies of the department of human rights, and the office of historical preservation of the state historical society of Iowa as interested agencies, and also to the Iowa department of transportation, and the Iowa department of natural resources, if such have not been designated as regulatory agencies.

d. Any amendments to the application shall be filed in a manner similar to that required of the application.

[Editorial change: IAC Supplement 12/29/10]

199—24.4(476A) Application for a certificate—contents. Each person or group of persons proposing to construct a facility after January 1, 1977, or a significant alteration to a facility shall file an application for certificate with the board, unless otherwise provided by these rules. The applicant may file a portion of an application and, in conjunction therewith, a request that the board accept such portion of the application pursuant to subrule 24.5(3) and conduct a separate phase of the proceeding with respect to issues presented by such portion of the application to the extent permitted pursuant to 24.5(3) and rule 199—24.9(476A). An application shall substantially comply with the following informational requirements:

24.4(1) In section 1, entitled "General Information," applicant shall include the following information:

a. The legal name, address, telephone number, facsimile transmission number, and E-mail address of the applicant and all other participants of the proposed facility at the time of filing, as well as the name of the person authorized to receive communications relating to the application on behalf of those persons, Iowa business address, if applicable, and principal place of business of the applicant.

b. The name and type of business of the applicant's and all other participants' parent companies and affiliates. The information must include percentages of ownership.

c. A complete description of the current and proposed rights of ownership in the proposed facility and current or planned purchase power contracts with respect to the proposed facility.

d. A general site description including a legal description of the site location, a map showing the coordinates of the site and its location with respect to state, county, and other political subdivisions, and prominent features such as cities, lakes, rivers and parks within the site impact area. Applicant shall also provide a more detailed map showing the location of the facility perimeter, utility property, railroads and other transportation facilities, abutting and adjacent properties, cities, lakes, rivers, parks, other public facilities, cemeteries and places of historical significance within one mile of the site boundary. The general site description should include a discussion of whether the proposed site is located in a flood plain.

e. A general description of the proposed facility including a description of the principal characteristics of the facility such as the capacity of the proposed facility in megawatts expressed by the contracted maximum generator nameplate MW rating, the net facility addition in MW, by net to the busbar rating, and the portion (in MW) of the design capacity of the proposed facility which is proposed to be available for use by each participant, the number and type of generating units, primary fuel source for each such unit, total hours of operation anticipated seasonally and annually, and output in MWH during these hours, expected capacity factors, a description of the general arrangement of major structures and equipment to provide the board with an understanding of the general layout of the facility, and a schedule for the facility's construction and utilization including the projected date significant site alteration is proposed to begin and the projected date the facility is to be placed into service. For this purpose, a group of several similar generating units operated together at the same location such that segregated records of energy output are not available shall be considered as a single unit.

f. A general description of all raw materials, including fuel, used by the proposed facility in producing electricity and of all wastes created in the production process. In addition to describing the wastes created in the production process, the applicant shall determine annual expected sulfur dioxide emissions from the facility and provide a plan for acquiring allowances sufficient to offset these emissions. The applicant shall describe all transportation facilities currently operating that will be available to serve the proposed facility and shall describe any additional transportation facilities needed to deliver raw materials and to remove wastes.

g. Identification, general description and chronology of all financial and other contractual commitments undertaken or planned to be undertaken with respect to the proposed facility.

h. A general map and description of the primary transmission corridors and the approximate routing of the rights-of-way. An analysis of the existing transmission network's capability to reliably support the proposed additional generation interconnection to the network. The analysis must also show that the interconnection to the transmission system is consistent with standard utility practices and the proposed interconnection does not degrade the adequacy, reliability, or operating flexibility

of the existing transmission system in the area. A system impact analysis performed by the operator of the transmission system with which the facility will be interconnected, as well as any analysis, in applicant's possession, submitted to an area reliability council, concerning the impact of the facility on the area grid, shall satisfy the foregoing requirements. The impact analysis must include both local area and regional impacts.

i. The applicant, if a public utility, must include a statement of total cost to construct the proposed facility. Such cost shall include, but shall not be limited to, the cost of all electric power generating units, all electric supply lines within the facility site boundary, all electric supply lines beyond the facility site boundary with voltage of 69 kilovolts or higher used for transmitting power from the facility to the point of junction with the distribution system or with the interconnected primary transmission system, all appurtenant or miscellaneous structures used and useful in connection with said facility or any part thereof, and all rights-of-way, lands or interest in lands, the use and occupancy of which are necessary or appropriate in the maintenance or operation of said facility.

j. The names and addresses of those owners and lessees of record or real property identified in 24.6(2)*"d"* and *"e."*

24.4(2) In section 2, entitled "Regulatory requirements," applicant shall include the following:

a. All information related to the regulatory agency and zoning authority requirements for permits or licenses necessary to construct, operate, and maintain the facility.

b. A listing of every state agency from which any approval or authorization concerning the proposed facility is required and a listing of zoning authorities.

c. Information equivalent to the information required in the rules and application forms of such state regulatory agencies and zoning authorities, to the extent such information is ready to be filed.

24.4(3) In section 3, entitled "Community impact," the applicant shall include an identification and analysis of the effects the construction, operation and maintenance of the proposed facility will have on the site impact area including, but not limited to, the following:

a. A forecast of the permanent impact of the construction, operation, and maintenance of the proposed facility on commercial and industrial sectors, housing, land values, labor market, health facilities, sewage and water, fire and public protection, recreational facilities, schools and transportation facilities.

b. A forecast of any temporary stress placed upon housing, schools or other community facilities as a result of a temporary influx of workers during the construction of the proposed facility.

c. A forecast of the impact of the proposed facility on property taxes of affected taxing jurisdictions. The forecast shall include the effects on property taxes caused by all community development proximately related to the construction of the proposed facility.

d. A forecast of the impact on agricultural production and uses.

e. A forecast of the impact on open space areas and areas of significant wildlife habitat. Such forecast shall include identification and description of the impact of the proposed facility on terrestrial and aquatic plants and animals.

f. A forecast of the impact on transportation facilities.

g. A forecast of the impact on cultural resources including known archaeological, historical and architectural properties, which are on, or eligible for, the National Register of Historic Places.

h. A forecast of the impact on landmarks of historic, religious, archaeological, scenic, natural or other cultural significance. Such information shall include applicant's plans to coordinate with the office of state archaeologist to reduce or obviate any adverse impact and the applicant's plans to coordinate with the state office of disaster services in the event of accidental release of contaminants from the proposed facility.

24.4(4) Site selection methodology. In section 4, entitled "Site selection methodology," applicant shall present information related to its selection of the proposed site for the facility. Such information shall include the following:

a. The general criteria used to select alternative sites and how these criteria were used to select the proposed site.

b. A discussion of the extent to which reliance upon eminent domain powers could be reduced by use of an alternative site, alternative generation method or alternative waste handling method.

199—24.5(476A) Initial board review: Application acceptance.

24.5(1) Upon the filing of the application or a portion of the application, the board and the appropriate regulatory agencies shall make an initial review thereof to determine if it is in substantial compliance with the requirements of rule 199—24.4(476A) which pertain thereto. If any significant deficiencies, including those noted by applicant, are determined to exist in the application, or such portion of the application by either the board or regulatory agency, the board shall notify the applicant specifying such deficiencies, within 45 days from the date of the filing of the application or such portion of the application.

24.5(2) Applicant shall have 30 days from notification of deficiencies to amend or request, for good cause, a reasonable extension of time to amend. In the event the applicant fails to amend within the time allowed or, after amendment, the application or portion thereof filed is not in substantial compliance with the requirements of rule 199—24.4(476A) which pertain thereto, the board may reject the application or such portion thereof. Such rejection shall constitute final agency action, but shall not preclude reapplication.

24.5(3) If the application or portion thereof, after amendment or otherwise, is in substantial compliance with the requirements of rule 199—24.4(476A) which pertain thereto, the board shall, within 45 days of the filing of the application or portion thereof or amendment thereto, accept the application or portion thereof and set the time and place for hearing as provided in rule 199—24.6(476A); provided, however, that upon acceptance of a partial application, the board may order separate proceedings on particular phases of the application, pursuant to rule 199—24.9(476A), where such partial application permits a finding to be made with regard to any of the facility siting criteria contained in subrule 24.10(2).

199—24.6(476A) Procedural schedule.

24.6(1) Upon acceptance of the application, the board shall establish a schedule for the certification proceeding which shall include:

a. A hearing to be commenced in accordance with rule 199—24.8(476A), no earlier than 90 days nor later than 150 days from the date of acceptance. This hearing shall be conducted in the county in which the construction of the greater portion of the facility is being proposed.

b. Provision for the publication of notice of the schedule for the hearing held by the board in the form provided in Iowa Code section 17A.12(2), which notice shall be published in a newspaper of general circulation in each county in which the proposed site is located once each week for two consecutive weeks with the second publication being no later than 30 days after acceptance of the application.

24.6(2) The board shall serve notice of the acceptance of the application and proceeding schedule upon the following:

a. All regulatory agencies, including Iowa department of transportation and the Iowa department of natural resources.

b. Interested agencies as determined by the board, including the office of state archaeologist and the office of historical preservation of the state historical society of Iowa.

c. County and city zoning authorities from the area in which the proposed site is located; and

d. All owners of record of real property located within one mile of the intersection of the transverse center-line axis and longitudinal center-line axis of the generator, or all such generator axis intersections where the proposed facility includes multiple generators, and all owners of record of real property located within 1000 linear feet of the proposed boundary, but outside any such one-mile radius.

e. All lessees of record of real property of one acre or more located within the site boundary or within 1000 linear feet outside of the proposed site boundary.

f. Other interested persons as determined by the board.

24.6(3) Status of notice recipient.

a. Those receiving notice under 24.6(2)*"a"* shall be deemed parties to the proceeding.

b. Such notice provided under 24.6(2)*"b," "c," "d," "e"* or *"f"* shall state that the recipient shall have the right to become an intervenor upon duly filing written notice of intervention.

199—24.7(476A) Informational meeting.

24.7(1) *Place of meeting.* Not less than 30 days prior to the filing of an application the applicant shall hold an informational meeting in the county of the proposed site for the facility. In the event the proposed site is in more than one county, such meeting shall be in that county containing the greatest portion of the proposed facility site.

24.7(2) *Meeting facilities.* The applicant shall be responsible for all negotiations and compensation for a suitable facility to be used for the informational meeting, including but not limited to a building or facility which is in substantial compliance with the requirements of the Americans with Disabilities Act Accessibility Guidelines, Chapter 4, where such a building or facility is reasonably available.

24.7(3) *Location.* The location of the meeting shall be reasonably accessible to all persons which may be affected by the granting of the certificate.

24.7(4) *Board approval.* Board approval shall be obtained for the proposed informational meeting date, time, and location.

24.7(5) *Personnel.* The prospective applicant shall provide qualified personnel to speak for the applicant in matters relating to the following:

a. Utility planning which has resulted in the proposed construction.

b. When the facility or significant alteration will be constructed.

c. In general terms the physical construction, appearance and location of major structures with respect to proposed property lines.

d. In general terms the property rights which the applicant shall seek including purchase, option to buy, and easement.

e. Procedures to be followed in contacting affected parties for specific negotiations in acquiring property rights.

f. Methods and factors used in arriving at offered compensation.

g. Manner in which payments are made including discussion of conditional easements, signing fees and time of payment.

h. Other factors or damages for which compensation is made.

i. If the undertaking is a joint effort, other participants shall be represented at the informational meeting by qualified personnel designated to speak for them.

24.7(6) *Conduct of the meeting.* A member of the board, or a hearing examiner designated by the board, shall serve as the presiding officer at the meeting and present an agenda for such meeting, which shall include a summary of the legal rights of affected legal landowners. No formal record of the meeting is required. The meeting shall be considered an opportunity for interested members of the public to raise questions regarding the proposal, and an opportunity for the applicant to respond.

24.7(7) *Notice.* At least one week prior to the time set for the informational meeting, the applicant shall cause to be published a notice of such meeting in a newspaper of general circulation in each county containing a portion of the proposed site impact area. The notice of the informational meeting shall contain the following statement: Persons with disabilities requiring assistive services or devices to observe or participate should contact the utilities board at (515)725-7300 in advance of the scheduled date to request that appropriate arrangements be made. Proof of such notice shall be provided to the board by applicant. Additional notice shall be made through press release to all newspapers of general circulation in each county containing a portion of the proposed site impact area and, as deemed appropriate by the board, electronic media.

This rule is intended to implement Iowa Code sections 476A.2 and 476A.12.

[Editorial change: IAC Supplement 12/29/10]

199—24.8(476A) Hearing procedure.

24.8(1) *General.* The proceedings conducted by the board pursuant to this chapter shall be treated in the same manner as a contested case pursuant to the provisions of Iowa Code chapter 17A. Except

where contrary to express provisions below, the hearing procedure shall conform to the board's rules of practice and procedure, 199—Chapter 7, IAC. The proceeding for the issuance of certificate may be consolidated with the contested case proceeding for determination of applicable ratemaking principles under Iowa Code section 476.53.

24.8(2) *Intervention.*

a. Notice of intervention. An agency not receiving notice pursuant to 24.6(2)*"b"* may become a party to the contested case proceeding by filing with the board an original and ten copies of a notice of intervention. Such notice shall contain a statement of the jurisdiction or interest of the particular agency with respect to the proposed facility.

b. Petition to intervene. Any other person wishing to become a party to the contested case proceeding may request to intervene in the proceeding by petition to intervene filed at least 30 days prior to the date of the scheduled hearing, but not afterward except for good cause shown. Such application shall specify the issues in which petitioner may contest before a regulatory agency or otherwise. A petition to intervene shall substantially comply with the form prescribed in 199—subrule 2.2(10). The original and ten copies of the petition shall be filed with the board. All other parties to the proceeding shall have the right to resist or respond to the petition to intervene within seven days subsequent to the petitioner's service thereof.

c. Board discretion. The board may, in its discretion, grant or deny such petition or may permit intervention by the petitioner limited to particular issues or to a particular phase or stage of the proceeding. The board shall, in exercising its discretion, consider the substantiality of the petitioner's rights allegedly affected by the granting or denial of the application and whether granting the intervention will unduly delay the proceeding or have no probative value to the proceeding. The granting of any petition to intervene shall not have the effect of changing or enlarging the issues specified in the board's notice of hearing or any prehearing order of the board unless the board shall, on motion, amend the same.

24.8(3) *Appearance.* If any regulatory agency fails to appear of record in the contested case proceeding conducted by the board, the board shall conclusively presume that the facility meets the regulatory agency's permit and licensing requirements and the regulatory agency shall immediately issue any license or permit required for the construction, operation, or maintenance of the facility.

24.8(4) *Discovery.* Discovery may begin after the commencement of the contested case proceeding. It will not be grounds for objection that the information sought will be inadmissible at the hearing if the information sought appears reasonably calculated to lead to the discovery of admissible evidence.

24.8(5) *Application for rehearing.* All applications for rehearing will be made and processed in accordance with Iowa Code section 17A.16(2). Applications for rehearing after decision made by the board must state the specific grounds upon which the application is based and must specify such findings of fact and conclusions of law and such terms or conditions of any certificate or amendment to certificate as are claimed to be erroneous, with a brief statement of the grounds of error. An application for rehearing shall substantially comply with the form prescribed in 199—subrule 2.2(13). The original and ten copies of the application shall be filed with the board.

199—24.9(476A) Separate hearings on separate issues.

24.9(1) *By motion.* The board, upon its own motion or on the motion of the applicant, may order separate phases on particular issues of the proceeding. Each phase shall be addressed to issues involved in applying one or more of the facility siting criteria set forth in subrule 24.10(2) and shall result in board findings with respect thereto.

24.9(2) *By agreement.* In accordance with agreements made pursuant to Iowa Code chapter 28E, with regulatory agencies, the board shall establish separate phases of the hearing process to determine whether the proposed facility will conform to the permit and licensing requirements of the regulatory agencies.

24.9(3) *Procedure.* Each such hearing phase shall be conducted in conformance with the requirements of rule 199—24.8(476A) or other rules of practice and procedure designated in the applicable chapter 28E agreement.

199—24.10(476A) Certification decision.

24.10(1) *Issuance of decision.* Upon the close of the record in the proceeding, the board shall expeditiously render a written decision with complete determinations as to the facility siting criteria or portion thereof under consideration, other necessary findings of fact or conclusions of law necessary to support the board's decision.

24.10(2) *Facility siting criteria.* In rendering its certification decision, the board shall consider the following criteria:

a. Whether the service and operations resulting from the construction of the facility are consistent with the legislative intent as expressed in Iowa Code section 476.53 and the economic development policy of the state as expressed in Iowa Code Title I, Subtitle 5, and will not be detrimental to the provision of adequate and reliable electric service. Such determination shall include whether the existing transmission network has the capability to reliably support the proposed additional generation interconnection to the network.

b. Whether the construction, maintenance, and operation of the proposed facility will be consistent with reasonable land use and environmental policies, and consonant with reasonable utilization of air, land, and water resources, considering available technology and the economics of available alternatives. Such determination shall include:

(1) Whether all adverse impacts attendant the construction, maintenance and operation of the facility have been reduced to a reasonably acceptable level;

(2) Whether the proposed site represents a reasonable choice among available alternatives;

(3) Whether the proposed facility complies with applicable city, county or airport zoning requirements and, if not, whether the location of the proposed facility at the proposed site is reasonably justified from an economic, technical, and social standpoint.

c. Whether the applicant is willing to construct, maintain, and operate the facility pursuant to the provisions of the certificate and the Act.

d. Whether the proposed facility meets the permit and licensing requirements of regulatory agencies.

e. Requirement for good engineering practice. The applicant shall use the applicable provisions in the publications listed below as standards of accepted good practice unless otherwise ordered by the board:

(1) Iowa Electrical Safety Code, as defined in 199 IAC 25.

(2) National Electrical Code, as defined in 199 IAC 25.

(3) Power Piping-ANSI standard B31.1-2004.

24.10(3) *Amendment.* If the board finds that the application and record in the proceeding does not support affirmative findings with regard to these criteria, the board will, in its order, specify any deficiencies determined to exist. The applicant shall have 30 days from the notification of the deficiencies to amend or, for good cause, to request a reasonable extension of time to amend the application or to request reopening of the record to correct the deficiencies, or both.

24.10(4) *Denial.* In the event the applicant fails to amend in a timely fashion, or after amendment or reopening the record, or both, the board is still unable to make an affirmative finding, the board will deny the application. Applicant may request rehearing on such denial in accordance with Iowa Code section 17A.16(2).

24.10(5) *Application approval.* If the board finds, after amendment or record reopening, or both, or otherwise, that affirmative findings are appropriate, the board shall approve the application and, in accordance with rule 199—24.12(476A), prepare a certificate for construction of the facility.

199—24.11(476A) Site preparation.

24.11(1) In the event no certificate has been issued after 90 days from the commencement of the hearing, the board may permit applicant to begin work to prepare the site for construction of the facility. Any activities conducted pursuant to this section shall have no probative value to the board's decision concerning the actual issuance of a certificate.

24.11(2) In the event the board denies an application for a certificate or an amendment to a certificate, applicants who have received permission to begin site preparation, pursuant to 24.11(1), shall restore the site, in accordance with the board order denying the application.

199—24.12(476A) Issuance of a certificate.

24.12(1) *General.* The certificate shall authorize construction, maintenance, and operation of the facility on the site designated in the certificate according to the following:

a. Those terms and conditions imposed by the board and stated in the certificate.

b. Those terms and conditions in licenses and permits issued by regulatory agencies before and during the proceeding.

c. Those terms and conditions which have been specifically recommended by regulatory agencies in the proceeding and declared by those regulatory agencies or the board as being necessary for the applicant to comply with requirements of licenses or permits then sought but not yet issued.

24.12(2) *Eminent domain.* The certificate shall give the applicant the power of eminent domain to the extent and under such conditions as the board approves, prescribes, and finds necessary for the public convenience, use, and necessity, proceeding in the manner of works of internal improvement under Iowa Code chapter 472.

24.12(3) *Certificate transfer.* A certificate may be transferred, subject to the approval of the board, to a person who agrees to comply with the terms of the certificate including any amendments to the certificate. Certificates shall be transferable by operation of law to any receiver, trustee or similar assignee under a mortgage, deed of trust or similar instrument.

24.12(4) *Application withdrawal.* Pursuant to Iowa Code section 476.53, a rate-regulated utility shall have the option of withdrawing its application for issuance of a certificate.

199—24.13(476A) Exemptions from certification application; application for amendment for certificate: Contents.

24.13(1) Application for amendment.

a. Each person or group of persons proposing a significant alteration to any facility which was constructed pursuant to a certificate issued by the board shall file an application for an amendment to a certificate in lieu of an application for a certificate.

b. Each person or group of persons proposing a significant alteration to any facility which was not constructed pursuant to a certificate issued by the board must file an application for such certificate unless:

(1) The facility has not attained full commercial rating and has not operated in excess of 80 percent of its maximum nameplate megawatt rating for ten hours daily for 45 consecutive days; and

(2) The significant alteration requires no more land than was required for the facility, is within the scope of publicly announced plans for the facility's construction, and entails no additional contracts for major components than those let for the facility.

24.13(2) All applications for amendment to a certificate shall be filed in accordance with rule 199—24.3(476A) and shall include:

a. A complete identification and discussion of the nature of the amendment proposed; and

b. A complete enumeration of the effects the amendment has on the accuracy of the information contained in the application for a certificate filed pursuant to rule 199—24.4(476A).

24.13(3) Upon board acceptance of the application in accordance with 24.13(1), the board shall establish a hearing schedule. At the board's discretion, the informational meeting and prehearing conference for this proceeding may be waived. Notice shall be in accordance with 24.6(2).

24.13(4) In the consideration of an application for a certificate, pursuant to 24.13(1)*"b,"* or amendment to a certificate, pursuant to 24.13(1)*"a,"* there shall be a rebuttable presumption that the decision criteria of 24.10(2) are satisfied.

24.13(5) Amendment to a certificate. In determining whether an amendment to a certificate will be issued to the applicant, the board will be guided by the criteria set forth in 24.10(2) to the extent applicable and appropriate.

This rule is intended to implement Iowa Code sections 17A.3, 474.5, 476.1, and 476.2.

199—24.14(476A) Assessment of costs. The applicant for a certificate, or an amendment to a certificate, shall pay all the costs and expenses incurred by the board in reaching a decision on the application including the costs of examinations of the site, the hearing, publishing of notice, board staff salaries, the cost of consultants employed by the board, and other expenses reasonably attributable to the proceeding.

This rule is intended to implement Iowa Code chapter 476A and sections 17A.3, 474.5, 476.1, and 476.2.

199—24.15(476A) Waiver. The board, if it determines that the public interest would not be adversely affected, may waive any of the requirements of this chapter. In determining whether the public interest would not be adversely affected, the board will consider the following factors:

1. The purpose of the facility.
2. The type of facility.
3. If the facility is for the applicant's own needs.
4. The effect of the facility on existing transmission systems.
5. Any other relevant factors.

In addition to other service requirements, the applicant must serve a copy of the waiver request on all owners of record of real property that adjoins the proposed facility site.

This rule is intended to implement Iowa Code sections 476A.1, 476A.2, 476A.4, 476A.6, 476A.7 and 476A.15.

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CHAPTER 25
IOWA ELECTRICAL SAFETY CODE
[Prior to 10/8/86, Commerce Commission[250]]

199—25.1(476,476A,478) General information.

25.1(1) *Authority.* The standards relating to electric and communication facilities in this chapter are prescribed by the Iowa utilities board pursuant to Iowa Code sections 476.1, 476.1B, 476.2, 476A.12, 478.19, and 478.20.

25.1(2) *Purpose.* The purpose of this chapter is to promote safe and adequate service to the public, to provide standards for uniform and reasonable practices by utilities, and to establish a basis for determining the reasonableness of such demands as may be made by the public upon the utilities. The rules apply to electric and communication utility facilities located in the state of Iowa and shall supersede all conflicting rules of any such utility. This rule shall in no way relieve any utility from any of its duties under the laws of this state.

199—25.2(476,476A,478) Iowa electrical safety code defined. The standard minimum requirements for the installation and maintenance of electric substations, generating stations, and overhead and underground electric supply or communications lines adopted below, collectively constitute the "Iowa Electrical Safety Code."

25.2(1) *National Electrical Safety Code.* The American National Standards Institute (ANSI) C2-2007 "National Electrical Safety Code" (NESC) as ultimately conformed to the ANSI-approved draft by correction of publishing errors through issuance of printed corrections is adopted as part of the Iowa electrical safety code, except Part 4, "Rules for Operation of Electric Supply and Communications Lines and Equipment," which is not adopted by the board.

25.2(2) *Modifications and qualifications to ANSI C2.* The standards set forth in ANSI C2 are modified or qualified as follows:

a. Introduction to the National Electrical Safety Code.

(1) The following paragraph replaces NESC 011B: "The National Electrical Safety Code (NESC) covers utility facilities and functions from the point of generation by the utility, or delivery from another entity, of electricity or communications signals through the utility system to the point of delivery to a customer's facilities."

(2) NESC 013A2 is modified to read as follows: "Types of construction and methods of installation other than those specified in the rules may be used experimentally to obtain information, if done where:

1. Qualified supervision is provided,
2. Equivalent safety is provided,
3. On joint-use facilities, all affected parties agree, and
4. Prior approval is obtained from the Iowa utilities board."

b. Minimum clearances.

(1) In any instance where minimum clearances are provided in Iowa Code chapter 478 which are greater than otherwise required by these rules, the statutory clearances shall prevail.

(2) The following clearances shall apply to all lines regardless of date of construction: NESC 232, vertical clearances for "Water areas not suitable for sailboating or where sailboating is prohibited," "Water areas suitable for sailboating. . .," and "Established boat ramps and associated rigging areas. . ."; and NESC 234E, "Clearance of Wires, Conductors, Cables or Unguarded Rigid Live Parts Installed Over or Near Swimming Areas With No Wind Displacement."

(3) Table 232-1, Footnote 21, is changed to read: "Where the U.S. Army Corps of Engineers or the state, or a surrogate thereof, issues a crossing permit, the clearances of that permit shall govern if equal to or greater than those required herein. Where the permit clearances are less than those required herein and water surface use restrictions on vessel heights are enforced, the permit clearances may be used."

(4) Except for clearances near grain bins, for measurements made under field conditions, the board will consider compliance with the overhead vertical line clearance requirements of Subsection 232 and Table 232-1 of the 1987 NESC indicative of compliance with the 1990 through 2007 editions of the

NESC. (For an explanation of the differences between 1987 and subsequent code edition clearances, see Appendix A of the 1990 through 2007 editions of the NESC.)

c. Reserved.

d. Rule 217C.1 is changed to read:

"The ground end of anchor guys exposed to pedestrian or vehicle traffic shall be provided with a substantial marker not less than eight feet long. The guy marker shall be of a conspicuous color such as yellow, orange, or red. Green, white, gray or galvanized steel colors are not reliably conspicuous against plant growth, snow, or other surroundings. Noncomplying guy markers shall be replaced as part of the utility's inspection and maintenance plan."

e. There is added to Rule 381G:

(3) Pad-mounted and other aboveground equipment not located within a fenced or otherwise protected area shall have affixed to its outside access door or cover a prominent "Warning" or other appropriate sign of highly visible color, warning of hazardous voltage and including the name of the utility. This rule shall apply to all signs placed or replaced after June 18, 2003.

f. There is added to the first paragraph of Rule 110.A.1, after the sentence stating, "Entrances not under observation of an authorized attendant shall be kept locked," the following sentences:

Entrances may be unlocked while authorized personnel are inside. However, if unlocked, the entrance gate must be fully closed, and must also be latched or fastened if there is a gate-latching mechanism.

g. Lines crossing railroad tracks shall comply with the additional requirements of 199 IAC 42.6(476), "Engineering standards for electric and communications lines."

25.2(3) *Grain bins.*

a. Electric utilities shall conduct annual public information campaigns to inform farmers, farm lenders, grain bin merchants, and city and county zoning officials of the hazards of and standards for construction of grain bins near power lines.

b. An electric utility may refuse to provide electric service to any grain bin built near an existing electric line which does not provide the clearances required by the American National Standards Institute (ANSI)C2-2007 "National Electrical Safety Code," Rule 234F. This paragraph *"b"* shall apply only to grain bins loaded by portable augers, conveyors or elevators and built after September 9, 1992, or to grain bins loaded by permanently installed augers, conveyors, or elevator systems installed after December 24, 1997.

25.2(4) *General rules.*

a. Joint-use construction. Where it is mutually agreeable between the electric supply company and the communication or cable television company, communication circuits or cables may be buried in the same trench or attached to the same supporting structure, provided this joint use is permitted by, and is constructed in compliance with, the Iowa electrical safety code.

b. Lines. In order to limit the residual currents and voltages arising from line unbalances, the resistance, inductance, capacitance and leakage conductance of each phase conductor of an electric supply circuit in any section shall be as nearly equal as practical to the corresponding quantities in the other phase conductors in the same section.

The ampacity of a multigrounded neutral conductor of an electric supply circuit shall be adequate for the load which it is required to carry. The ampacity of a multigrounded neutral conductor of an electric supply circuit shall not be less than 60 percent of that of any phase conductor with which it is associated, except for three phase four wire wye circuits where it shall have ampacity not less than 50 percent of that of any associated phase conductor. In no case shall the resistance of a multigrounded neutral conductor exceed 3.6 ohms per mile. (This does not modify the mechanical strength requirements for conductors.) A multigrounded conductor installed and utilized primarily for lightning shielding of the associated phase conductors need not comply with the above percentage ampacity requirements for neutral conductors.

Where the neutral conductor of the electric supply circuit is not multigrounded or in an inductive exposure involving communication or signal circuits and equipment where the controlling frequencies

are 360 Hertz or lower, any neutral conductor shall have the same ampacity as the phase conductors with which it is associated.

25.2(5) *Other references adopted.*

a. The "National Electrical Code," ANSI/NFPA 70-2008, is adopted as a standard of accepted good practice for customer-owned electrical facilities beyond the utility point of delivery, except for installations subject to the provisions of the state fire marshal standards in 661 IAC 504.1(103).

b. "The Lineman's and Cableman's Handbook," Eleventh Edition; Shoemaker, Thomas M. and Mack, James E.; New York, McGraw-Hill Book Co., is adopted as a recommended guideline to implement the "National Electrical Safety Code" or "National Electrical Code," and for developing the inspection and maintenance plans required by 199 IAC 25.3(476,478).

[**ARC 7962B**, IAB 7/15/09, effective 8/19/09]

199—25.3(476,478) Inspection and maintenance plans.

25.3(1) *Filing of plan.* Each electric utility shall adopt and file with the board a written plan for inspecting and maintaining its electric supply lines and substations (excluding generating stations) in order to determine the necessity for replacement, maintenance, and repair, and for tree trimming or other vegetation management. If the plan is amended or altered, revised copies of the appropriate plan pages shall be filed.

25.3(2) *Annual report.* Each utility shall include as part of its annual report to the board, as required by 199—Chapter 23, certification of compliance with each area of the inspection plan or a detailed statement on areas of noncompliance.

25.3(3) *Contents of plan.* The inspection plan shall include the following elements:

a. General. A listing of all counties or parts of counties in which the utility has electric supply lines in Iowa. If the utility has district or regional offices responsible for implementation of a portion of the plan, the addresses of those offices and a description of the territory for which they are responsible shall also be included.

b. Inspection of lines, poles, and substations.

(1) Inspection schedules. The plan shall contain a schedule for the periodic inspection of the various units of the utility's electric plant. The period between inspections shall be based on accepted good practice in the industry, but for lines and substations shall not exceed ten years for any given line or piece of equipment. Lines operated at 34.5 kV or above shall be inspected at least annually for damage and to determine the condition of the overhead line insulators.

(2) Inspection coverage. The plan shall provide for the inspection of all supply line and substation units within the adopted inspection periods and shall include a complete listing of all categories of items to be checked during an inspection.

(3) Conduct of inspections. Inspections shall be conducted in a manner conducive to the identification of safety, maintenance, and reliability concerns or needs.

(4) Instructions to inspectors. Copies of instructions or guide materials used by utility inspectors in determining whether a facility is in acceptable condition or in need of corrective action or further investigation.

c. Tree trimming or vegetation management plan.

(1) Schedule. The plan shall contain a schedule for periodic tree trimming or other measures to control vegetation growth under or along the various units of the utility's electric plant. The period between inspections shall be based on accepted good practice in the industry and may vary depending on the nature of the vegetation at different locations.

(2) Procedures. The plan shall include written procedures for vegetation management. The procedures shall promote the safety and reliability of electric lines and facilities. Where tree trimming is employed, practices shall be adopted that will protect the health of the tree and reduce undesirable regrowth patterns.

d. Pole inspections. Pole inspections shall periodically include an examination of the poles that includes tests in addition to visual inspection in appropriate circumstances. These additional tests may include sounding, boring, groundline exposure, and, if applicable, pole treatment.

25.3(4) *Records.* Each utility shall keep sufficient records to demonstrate compliance with its inspection and vegetation management plans. For each inspection unit, the records of line and substation inspections and pole inspections shall include the inspection date(s), the findings of the inspection, and the disposition or scheduling of repairs or maintenance found necessary during the inspection. For each inspection unit, the records of vegetation management shall include the date(s) during which the work was conducted. The records shall be kept until two years after the next periodic inspection or vegetation management action is completed or until all necessary repairs and maintenance are completed, whichever is longer.

25.3(5) *Guidelines.* Applicable portions of Rural Utilities Service (RUS) Bulletins 1730-1, 1730B-121, and 1724E-300 and "The Lineman's and Cableman's Handbook" are suggested as guidelines for the development and implementation of an inspection plan. ANSI A300 (Part 1)-2001, "Pruning," and Section 35 of "The Lineman's and Cableman's Handbook" are suggested as guides for tree trimming practices.

199—25.4(476,478) Correction of problems found during inspections. Corrective action shall be taken within a reasonable period of time on all potentially hazardous conditions, instances of safety code noncompliance, maintenance needs, potential threats to safety and reliability, or other concerns identified during inspections. Hazardous conditions shall be corrected promptly.

199—25.5(476,478) Accident reports. This rule applies to all owners or operators of electrical facilities subject to the safety jurisdiction of the board under this chapter.

25.5(1) All owners and operators of electrical facilities subject to the safety jurisdiction of the board shall provide the board with a 24-hour contact number where the board can obtain immediate access to a person knowledgeable about any incidents involving contact with energized electrical facilities.

25.5(2) All owners and operators of electrical facilities subject to the safety jurisdiction of the board shall notify the board of any incident or accident involving contact with energized electrical facilities that meets the following conditions:

a. An employee or other person coming in contact with energized electrical facilities which results in death or personal injury necessitating in-patient hospitalization.

b. Estimated property damage of $15,000 or more to the property of the utility and others.

c. Any other incident considered significant by the company.

25.5(3) The board shall be notified by telephone immediately, or as soon as practical thereafter, by calling the board duty officer at (515)745-2332 or by E-mail to iubdutyofficer@iub.iowa.gov. The caller shall leave a telephone number of a person who can provide the following information:

a. The name of the company, the name and telephone number of the person making the report, and the name and telephone number of a contact person knowledgeable about the incident.

b. The location of the incident.

c. The time of the incident.

d. The number of deaths or personal injuries requiring in-patient hospitalization and the extent of those injuries.

e. Initial estimate of damages.

f. A summary of the significant information available regarding the probable cause of the incident and extent of damages.

g. Any oral or written report made to a federal agency, the agency receiving the report, and the name and telephone number of the person who made or prepared the report.

25.5(4) Written incident reports. Within 30 days of the date of the incident, the owner or operator shall file a written report with the board. The report shall include the information required for telephone notice in subrule 25.5(2), the probable cause as determined by the company, the number and cause of any deaths or personal injuries requiring in-patient hospitalization, and a detailed description of property damage and the amount of monetary damages. If significant additional information becomes available

at a later date, a supplemental report shall be filed. Duplicate copies of any written reports filed with or submitted to a federal agency concerning the incident shall also be provided to the board.
[Editorial change: IAC Supplement 12/29/10]

These rules are intended to implement Iowa Code chapter 478.

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[Editorial change: IAC Supplement 12/29/10]

◊ Two or more ARCs

CHAPTER 26
RATE CASES, TARIFFS, AND RATE REGULATION ELECTION PRACTICE AND PROCEDURE

[Prior to 11/9/05, see 199—Ch 7]

199—26.1(17A,476) Scope and applicability.

26.1(1) This chapter contains procedural rules applicable only to rate cases, tariff filings, and rate regulation election by electric cooperatives. The board's general contested case procedural rules that also apply to these types of proceedings are contained in 199—Chapter 7.

26.1(2) The purpose of these rules is to facilitate the transaction of business before the board and to promote the just resolution of controversies. Consistent with this purpose, the application of any of these rules, unless otherwise required by law, may be waived by the board pursuant to 199—1.3(17A,474,476).

199—26.2(17A,476) Defective filings. No application, pleading, document, testimony or other submission filed with a tariff incorporating changes in rates, charges, schedules, or regulations for public utility service shall be rejected as defective under this rule after the date of a board order docketing investigation of the tariff as a formal proceeding.

199—26.3(17A,476) Proposal of settlements. In proposed settlements which resolve all revenue requirement issues in a rate case proceeding, parties to the settlement shall jointly file the revenue requirement calculations reflecting the adjustments proposed to be settled. In proposed settlements which resolve some revenue requirement issues in a rate case proceeding and retain some issues for litigation, each party to the settlement who has previously filed a complete revenue requirement calculation shall file its revenue requirement calculation reflecting the adjustments proposed to be settled and any remaining issues to be litigated. In proposed settlements which produce an agreed-upon revenue requirement as a mutually acceptable outcome to the proceeding without an agreement on each revenue requirement issue, parties to the settlement shall jointly file schedules reflecting the specific adjustments for which the parties reached agreement. For those issues included in the proposed settlement which were not specifically resolved, the schedules should identify the range between the positions of the parties.

199—26.4(476) Rate case expense.

26.4(1) A utility making an application pursuant to Iowa Code section 476.6 shall file, within one week of docketing of the rate case, the estimated or, if available, actual expenses incurred or to be incurred by the utility in litigating the rate case. Except for expenses incurred in preparation of the rate filing and notification of customers, the expenses shall be limited to expenses incurred in the time period from the date the initial application is filed through the utility's reply brief. Each expense shall be designated as either estimated or actual.

26.4(2) Estimated or, if available, actual expenses shall identify specifically:

a. Printing costs for the following:
(1) Rate notification letters
(2) Initial filing
(3) Testimony
(4) Briefs
(5) Other (specify)
b. Postage costs
c. Outside counsel cost
(1) Number of attorneys engaged as outside counsel
(2) Hours
(3) Cost/hour
d. Outside expert witness/consultant
(1) Number of outside consultants employed
(2) Hours per consultant employed

(3) Cost/hour per consultant employed

e. Expenses stated by individual for both outside consultants and utility personnel

(1) Travel

(2) Hotel

(3) Meals

(4) Other (specify)

f. Other (specify)

26.4(3) Rate case expense shall not include recovery for expenses that are otherwise included in test year expenses, including salaries for staff preparing filing, staff attorneys, and staff witnesses. Rate case expense shall include only expenses not covered by test year expenses for the period stated in subrule 26.4(1).

26.4(4) Total allowable rate case expense shall include expenses incurred by board staff and the consumer advocate for the time period stated in subrule 26.4(1). The rate case expense to be filed by the utility shall not include these expenses.

26.4(5) The reasonableness of the estimates shall be litigated during the proceeding. At the request of the consumer advocate or the utilities board, company shall make witnesses available on any item included in the estimated rate case expense for cross-examination during the hearing.

26.4(6) Actual utility expenses shall be filed in the same format and detail as estimated expenses and shall be filed within two weeks after filing the final brief. All material variances shall be fully supported and justified.

26.4(7) The board may schedule any additional hearings to litigate the reasonableness of the final expenses.

This rule is intended to implement Iowa Code section 476.6(8).

199—26.5(476) Applications and petitions.

26.5(1) *Customer notification procedures.*

a. Definitions. Terms not otherwise defined in these rules shall be understood to have their usual meaning.

(1) "Rates" shall mean amounts per unit billed to customers for a recurring service or commodity rendered or offered by the public utility. "Rate amounts" shall mean the total bill rendered to a customer pursuant to a given rate schedule.

(2) "Charges" shall mean amounts billed to customers for a nonrecurring service or commodity rendered or offered by the public utility.

(3) "Commodity" or "commodities" shall mean water, electricity, or natural gas.

(4) "Effective date" shall mean the date on which the first customer begins receiving the service or commodity under the new rate or charge.

b. Notification of customers. All public utilities, except those exempted from rate regulation by Iowa Code section 476.1 which propose to increase rates or charges, shall mail or deliver a written notice pursuant to paragraph *"c"* or *"d"* to all customers in all affected rate classifications. The written notice shall be mailed or delivered before the application for increase is filed, but not more than 62 days prior to the filing. Any public utility exempt from rate regulation by Iowa Code section 476.1, which proposes to increase rates or charges, shall mail or deliver, not less than 30 days prior to the proposed effective date, a written notice pursuant to paragraph *"c"* or *"d"* of the rate or charge increase to all customers in all affected rate classifications.

Provided, however, that if a telephone utility is proposing to increase rates for only interexchange services, excluding EAS and intrastate access services, the utility shall cause the notice of proposed increase to be published, in at least one newspaper of general circulation in each county where such increased rates are proposed to be effective. The notice shall be published at least twice in such newspaper no more than 62 days prior to the time the application for the increase is filed with the board.

c. Standardized notice.

(1) Rate-regulated utilities. Any rate-regulated utility company may use the following forms for notification of its customers without seeking prior board approval. If the utility is asking for a general

and interim increase, it should use Form A below. If the utility is asking for only a general increase, it should use Form B below.

Form A

Dear Customer:

(Company Name) (We) are asking the Iowa Utilities Board for an increase in (type of service) utility (rates) (and) (charges) with a proposed effective date of (date).

The proposed increase in annual revenues will be approximately $(number), or (number)%.

Although the effect of the proposed increase on your bill may vary depending upon the type and extent of usage, the (average monthly increase per customer for the primary customer classes) (and) (actual increase in nonrecurring charges per customer) (is) (are):

(Charges) (Customer Class)	Current (Charge) (Monthly Rate)	+	Proposed Increase	=	Proposed (Charge) (Monthly Rate)	Percentage Increase

This proposed increase in (rates) (and) (charges) may be docketed by the Board, which suspends the effective date of the proposed (rates) (and) (charges). If the proposed (rates) (and) (charges) are suspended, we are asking the Board for temporary authority to place into effect the following interim increase (collected subject to refund), to be effective (date). The Board may set interim (rates) (and) (charges) other than these:

Proposed Interim Rate Increase

(Charges) (Customer Class)	Current (Charge) (Monthly Rate)	+	Proposed Increase	=	Proposed (Charge) (Monthly Rate)	Percentage Increase

After a thorough investigation, the Board will order final (rates) (and) (charges) which may be different from those proposed, and determine when the (rates) (and) (charges) will become effective. If the final (rates) (and) (charges) are lower than the interim (rates) (and) (charges), the difference between the final and interim (rates) (and) (charges) will be refunded with interest.

You have the right to file a written objection to this proposed increase with the Board and to request a public hearing. The address of the Board is: Iowa Utilities Board, 1375 E. Court Avenue, Room 69, Des Moines, Iowa 50319-0069. The Board should be provided with any facts that would assist it in determining the justness and reasonableness of this requested increase. This information will be made available to the Consumer Advocate, who represents the public interest in rate cases before the Board.

A written explanation of all current and proposed rate schedules is available without charge from your local business office. If you have any questions, please contact your local business office.

Form B

Dear Customer:

(Company Name) (We) are asking the Iowa Utilities Board for an increase in (type of service) utility (rates) (and) (charges) with a proposed effective date of (date).

The proposed increase in annual revenues will be approximately $(number), or (number)%.

Although the effect of the proposed increase on your bill may vary depending upon the type and extent of usage, the (average monthly increase per customer for the primary customer classes) (and) (actual increase in nonrecurring charges per customer) (is) (are):

(Charges) (Customer Class)	Current (Charge) (Monthly Rate)	+	Proposed Increase	=	Proposed (Charge) (Monthly Rate)	Percentage Increase

This proposed increase in (rates) (and) (charges) may be docketed by the Board, which suspends the effective date of the proposed (rates) (and) (charges). After a thorough investigation, the Board will

order final (rates) (and) (charges) which may be different from those we requested. These final (rates) (and) (charges) will become effective at a date set by the Board.

You have the right to file a written objection to this proposed increase with the Board and to request a public hearing. The address of the Board is: Iowa Utilities Board, 1375 E. Court Avenue, Room 69, Des Moines, Iowa 50319-0069. The Board should be provided with any facts that would assist it in determining the justness and reasonableness of this requested increase. This information will be available to the Consumer Advocate, who represents the public interest in rate cases before the Board.

A written explanation of all existing and proposed rate schedules is available without charge from your local business office. If you have any questions, please contact your local business office.

(2) Utilities not subject to rate regulation. A utility not subject to rate regulation may use the following form for notification of its customers without seeking prior board approval.

Dear Customer:

On (date), (responsible party) approved an increase in (rates) (and) (charges) affecting prices for (type of service) that you receive. The increase will apply to your usage beginning on (date).

The increase in annual revenues will be approximately $(number), or (number)%.

Although the effect of the increase on your bill may vary depending upon the type and extent of usage, the (average monthly increase per customer for the primary customer classes) (and) (actual increase in nonrecurring charges per customer) (is) (are):

(Charges) (Customer Class)	Current (Charge) (Monthly Rate)	+	Proposed Increase	=	(Charge) (Monthly Rate)	Percentage Increase

A written explanation of all current rate schedules is available without charge from our local business office. If you have any questions, please contact our business office.

(3) General requirements for a form notice. The standardized notice provided under this subsection shall be of a type size and of a quality which is easily legible. A copy of the notice with dates, cost figures, and cost percentages shall be filed with the board at the time of customer notification.

Any utility offering services or systems involving detailed rate schedules must include in its notification to customers a paragraph specifically noting the services or systems for which any increase is proposed and advising customers to contact the utility's local business office for further explanation of the increase.

Any "average" used in the standard form shall be a median average.

d. Other customer notification forms.

(1) Prior approval. Any public utility, as defined in Iowa Code section 476.1, which proposes to increase rates or charges and is not in substantial compliance with the form prescribed in 26.5(1)*"c"* above, shall submit to the board not less than 30 days before providing notification to its customers in accordance with 26.5(1)*"b,"* ten copies of such proposed notice for approval. The board, for good cause shown, may permit a shorter period for approval of the proposed notice.

(2) Form. The proposed notice as submitted to the board pursuant to 26.5(1)*"d"*(1) may contain blank spaces for dates, cost figures and cost percentages; however, a copy of the approved notice with dates, cost figures, and cost percentages shall be filed with the board at the time of the customer notification. The form of the notice, as approved by the board, may not be altered in the final form except to include dates, cost figures, and cost percentages reflecting the latest updates. The notice shall be of a type size and of a quality which is easily legible and shall be of the same format as that which was approved by the board.

(3) Required content of notification. The notice submitted for approval pursuant to 26.5(1)*"d"*(1) shall include, at a minimum, all of the information contained in the standard notice of 26.5(1)*"c."*

(4) Notice of deficiencies. Within 30 days of the proposed notice's filing, the utility shall be notified of either the approval of the notice or of any deficiencies in the proposed notice. In the event deficiencies are found to exist in the proposed notice, the board will describe the corrective measures necessary to

bring the notice into compliance with Iowa Code chapter 476 and board rules. A notice found to be deficient under this rule shall not constitute adequate notice under Iowa Code section 476.6.

(5) Fuel adjustment clause. Nothing in this subsection shall be taken to prohibit a public utility from establishing a sliding scale of rates and charges or from making provision for the automatic adjustment of rates and charges for public utility service, provided that a schedule showing such sliding scale or automatic adjustment of rates and charges is first filed with the board. Such adjustment factors that result from the sliding scale shall be printed on the customer's bill.

e. Reserved.

f. Delivery of notification.

(1) The notice, as it appears in 26.5(1)*"c"* or as approved by the board in accordance with 26.5(1)*"d,"* shall be mailed or delivered to all affected customers pursuant to the timing requirements of 26.5(1)*"b."*

(2) Rate-regulated utilities. Notice of all proposed increases may be mailed to all affected customers. The notice may be mailed with a regularly scheduled mailing of the utility. Notice, except for proposed nonrecurring service charge increases, shall be conspicuously marked, "Notice of proposed rate increase," on the notice itself. If a separate mailing is utilized by a utility for customer notification except for proposed nonrecurring service charge increases, the outside of the mailing shall also be conspicuously marked, "Notice of proposed rate increase."

(3) Utilities not subject to rate regulation. Notice of all increases may be mailed to all affected customers. The notice may be mailed with a regularly scheduled mailing of the utility. Notice of all increases, except nonrecurring service charge increases, shall be conspicuously marked, "Notice of rate increase," on the notice itself. If a separate mailing is utilized by a utility for customer notification of an increase, except a nonrecurring service charge increase, the outside of the mailing shall also be conspicuously marked, "Notice of rate increase." This subparagraph does not apply to municipal utilities.

(4) Failure of the postal service to deliver the notice to any customers shall not invalidate or delay a proposed rate increase proceeding.

(5) After the date the first notice is mailed or delivered to any affected customer and until such rates are resolved in proceedings before the board, any person who requests service and is affected by the proposed increase in rates shall receive a notice specified in paragraph 26.5(1)*"b"* not later than 60 days after the date of commencement of service to the customer.

(6) Approved notice will be required for each filing proposing an increase that is not directly identifiable with a previous customer notification.

(7) This subrule shall not apply to telephone utilities proposing to increase rates for only interexchange services, excluding EAS and intrastate access services.

26.5(2) *Applications filed in accordance with the provisions of Iowa Code section 476.7.*

a. Any rate-regulated public utility filing an application with the board requesting a determination of the reasonableness of its rates, charges, schedules, service, or regulations shall submit at the time the application is filed, factual evidence and written argument offered in support of its filing and provided that the public utility is not a rural electric cooperative, it shall also submit affidavits containing testimonial evidence in support of its filing for a general rate increase. All such testimony and exhibits shall be given or presented by competent witnesses, under oath or affirmation, at the proceeding ordered by the board as a result of the application, and the proceeding itself shall be governed by the applicable provisions of 199—Chapter 7 and rule 199—26.4(476).

b. All of the foregoing requirements shall likewise apply in the event the board shall, on its own motion, initiate a formal proceeding to determine the reasonableness of a public utility's rates, charges, schedules, service, or regulations.

26.5(3) *Tariffs to be filed.* A rate-regulated public utility shall not make effective any new or changed rate, charge, schedule, or regulation until it has been approved by the board and the board has determined an effective date, except as provided in Iowa Code section 476.6, subsections 11 and 13. If the proposed new or changed rate, charge, schedule, or regulation is neither rejected nor approved by the board, the board will docket the tariff filing as a formal proceeding within 30 days after the filing date. Proposed new or changed rates, charges, schedules, or regulations which contain energy efficiency

expenditures and related costs which are incurred after July 1, 1990, for demand-side programs shall not be included in a rate-regulated utility's proposed tariff which relates to a general increase in revenue. A utility may propose to recover the costs of process-oriented industrial assessments not related to energy efficiency as defined in rule 199—35.2(476). The filing is not a contested case proceeding under the Iowa administrative procedure Act unless and until the board dockets it as a formal proceeding. No person will be permitted to participate in the filing prior to docketing, except that the consumer advocate and any customer affected by the filing, except as limited by 199—subrules 22.12(1) and 22.13(1), may submit within 20 days after the filing date a written objection to the filing and a written request that the board docket the filing, which request the board may grant in its discretion. Such written objections and requests for docketing shall set forth specific grounds relied upon in making the objection or request.

26.5(4) *Letter of transmittal.* Three copies of all tariffs and all additional, original, or revised sheets of tariffs and the accompanying letter of transmittal shall be filed with the board and shall include or be accompanied with such information as is necessary to explain the nature, effect, and purpose of the tariff or additional, original, or revised sheets submitted for filing. Such information shall include, when applicable:

a. The amount of the aggregate annual increase or decrease proposed.

b. The names of communities affected.

c. The number and classification of customers affected.

d. A summary of the reasons for filing and such other information as may be necessary to support the proposed changes.

e. A marked version of the pages to be changed or superseded showing additions and deletions, if the tariff is prepared with word processing software supporting such marking. All new language must be marked by highlight, background shading, bold text, or underlined text. Deleted language must be indicated by strike-through. The marked version may be in either paper or electronic form and may be prepared manually or by word processing. When a marked version is infeasible or not meaningful, the letter or transmittal should state the reason for its omission.

26.5(5) *Evidence.* Unless otherwise authorized by the board in writing prior to filing, a utility must when proposing changes in tariffs or rate schedules, which changes relate to a general increase in revenue, prepare and submit with its proposed tariff the following evidence in addition to the information required in 26.5(8). The board shall act on requests for waivers not later than 14 days after filing of those requests. If no action is taken on a request for waiver, it shall be deemed denied.

a. Factors relating to value. A statement showing the original cost of the items of plant and facilities, for the beginning and end of the last available calendar year, any other factors relating to the value of the items of plant and facilities the utility deems pertinent to the board's consideration, together with information setting forth budgeting accounts for the construction of scheduled improvements.

b. Comparative operating data. Information covering the latest available calendar year immediately preceding the filing date of the application.

(1) Operating revenue and expenses by primary account.

(2) Balance sheet at beginning and end of year.

c. Test year and pro forma income statements. Schedules setting forth revenues, expenses, net operating income of the last available calendar year, the adjustment of unusual items, and by adjustment to reflect operations for a full year under existing and proposed rates.

d. Additional evidence for rural electric cooperatives. In addition to the foregoing evidence, a rural electric cooperative shall file schedules setting forth utility long-term debt and debt costs, accrued utility operating margins and other components of patronage capital, the cooperative's plan to refund utility patronage credits, the ratio of utility long-term debt to retained utility operating margins, the times interest earned ratio, the debt service coverage, authorized utility construction programs, utility operating revenues from base rates, and utility operating revenues from power cost adjustment clauses.

e. Additional evidence for investor-owned utilities. In addition to the foregoing evidence, an investor-owned utility shall file, at the same time the proposed increase is filed, the following information. For the purposes of these rules, "year of filing" means the calendar year in which the filing is made.

Unless otherwise specified in these rules, the information required shall be based upon the calendar year immediately preceding the year of filing.

(1) Rate base for both total company and Iowa jurisdictional operations calculated by utilizing a 13-month average of month-ending balances ending on December 31 of the year preceding the year of filing, and also calculated on a year-end basis, except for the cash working capital component of this figure, which will be computed on the basis of a lead-lag study as set forth in subparagraph (5).

The rate base for the Iowa jurisdictional operations of rate-regulated telephone utilities will be computed on the basis of actual month-end balances which have been verified and adjusted to reflect the results of true-up procedures. True-up is the comparison of actual usage for each deregulated service with any previous estimates of deregulated usage for a given time period for the purpose of adjusting rate base and income statement allocations between deregulated and regulated services. Trued-up month-end balances for each deregulated service will be completed through the end of the test year prior to the date of filing a general rate case.

(2) Revenue requirements for both total company and Iowa jurisdictional operations to include: operating and maintenance expense, depreciation, taxes, and return on rate base. The Iowa jurisdictional expenses of rate-regulated telephone utilities will be adjusted to reflect allocation factors which have been computed as a result of actual month-end balances which have been verified and adjusted to reflect the results of true-up procedures. True-up is the comparison of actual usage for each deregulated usage for a given time period for the purpose of adjusting rate base and income statement allocations between deregulated and regulated services. Trued-up month-end balances for each deregulated service will be completed through the end of the test year prior to the date of filing a general rate case.

(3) Capital structure calculated utilizing a 13-month average of month-ending balances ending on December 31 of the year preceding the year of filing, and also calculated on a year-end basis.

(4) Schedules supporting the proposed capital structure, schedules showing the calculation of the proposed capital cost for each component of the capital structure and schedules showing requested return on rate base with capital structure and corresponding capital cost.

(5) Cash working capital requirements, including a recent lead-lag study which accurately represents conditions during the test period. For the purposes of this rule, a lead-lag study is defined as a procedure for determining the weighted average of the days for which investors or customers supply working capital to operate the utility.

(6) Complete federal and state income tax returns for the two calendar years preceding the year of filing and all amendments to those returns. If a tax return or amendment has not been prepared at the time of filing, the return shall be filed with the board under this subrule at the time it is filed with the Internal Revenue Service or the state of Iowa department of revenue.

(7) Schedule of monthly Iowa jurisdictional expense by account as required by chapter 16 of the board's rules unless, upon application of the utility and prior to filing, the board finds that the utility is incapable of reporting jurisdictional expense on a monthly basis and prescribes another periodic basis for reporting jurisdictional expense.

(8) For gas, electric and water utilities, a schedule of monthly consumption (units sold) and revenue by customer-rate classes, reflecting separately revenue collected in base rates and adjustment clause revenues. For telephone companies, a rate matrix as set forth in the company's annual report (page B-16), shall be filed along with a statement of the total amount of revenue produced under the rate matrix.

(9) Schedules showing that the rates proposed will produce the revenues requested. In addition to these schedules, the utility shall submit in support of the design of the proposed rate a narrative statement describing and justifying the objectives of the design of the proffered rate. If the purpose of the rate design is to reflect costs, the narrative should state how that objective is achieved, and should be accompanied by a cost analysis that would justify the rate design. If the rate design is not intended to reflect costs, a statement should be furnished justifying the departure from cost-based rates. This filing shall be in compliance with all other rules of the board concerning rate design and cost studies.

(10) All monthly or periodic financial and operating reports to management beginning in January two years preceding the year of filing. The item or items to be filed under this rule include: (a) reports of sales, revenue, expenses, number of employees, number of customers, or similar data; (b) related

statistical material. This requirement shall be a continuing one, to remain in effect through the month that the rate proceeding is finally resolved. Notwithstanding other provisions concerning the number of copies to be filed, one copy of each report shall be filed under this rule.

(11) Schedule of monthly tax accruals separated between federal, state, and property taxes, including the methods used to determine these amounts.

(12) Allocation methods, including formulas, supporting revenue, expense, plant or tax allocations.

(13) Schedule showing interest rates, dividend rates, amortizations of discount and premium and expense, and unamortized 13 monthly balances of discount and premium and expense, ending on December 31 of the year preceding the year of filing, for long-term debt and preferred stock.

(14) Schedule showing the 13 monthly balances of capital stock expense associated with common stock, ending on December 31 of the year preceding the year of filing.

(15) Schedule showing the 13 monthly balances of capital surplus, separated between common and preferred stock, ending on December 31 of the year preceding the year of filing. For the purpose of this rule, capital surplus means amounts paid in that are less than or are in excess of par value of the respective stock issues.

(16) Stockholders' reports, including supplements for the year of filing and the two preceding calendar years. If such reports are not available at the time of filing, they shall be filed immediately upon their availability to stockholders.

(17) If applicable, securities and exchange commission Form 10Q for all past quarters in the year of filing and the preceding calendar year, and Form 10K for the two preceding calendar years. If these forms have not been filed with the Securities and Exchange Commission at the time the rate increase is filed, they shall be filed under this subrule immediately upon filing with the Securities and Exchange Commission. This requirement is not applicable for any such reports which are routinely and formally filed with the board.

(18) Any prospectus issued during the year of filing or during the two preceding calendar years.

(19) Consolidated and consolidating financial statements.

(20) Revenue and expenses involving transactions with affiliates and the transfer of assets between the utility and its affiliates.

(21) A schedule showing the following for each of the 15 calendar years preceding the year of filing, and for each quarter from the first quarter of the calendar year immediately preceding the year of filing through the current quarter.

Earnings, annual dividends declared, annual dividends paid, book value of common equity, and price of common equity (each item should be shown per average actual common share outstanding, adjusted for stock splits and stock dividends).

Rate of return to average common equity.

Common stock earnings retention ratio.

For common stock issued pursuant to tax reduction act stock ownership plans, employee stock option plans, and dividend reinvestment plans: net proceeds per common share issued, and number of shares issued and previously outstanding at the beginning of the year. This shall be set forth separately for each of the three types of plans, and reported as annual aggregates or averages.

For other issues of common stock: net proceeds per common share issued, and number of shares issued and previously outstanding for each issue of common stock.

(22) If the utility is applying for a gas rate increase, a schedule for weather normalization, including details of the method used.

(23) All testimony and exhibits in support of the rate filing attached to affidavits of the sponsoring witnesses. All known and measurable changes in costs and revenues upon which the utility relies in its application shall be included.

Unless otherwise required, an original plus ten copies of all testimony and exhibits, and four copies of all other information, shall be filed. Three copies of each of the preceding items shall be provided to the consumer advocate. In addition, two electronic copies of each computer-generated exhibit which complies with the standards in 199—7.7(476) and two copies of a brief description of the software and hardware requirements of noncomplying electronic copies of computer-generated exhibits shall be filed

with the board and the consumer advocate. Two copies of the noncomplying electronic copies shall be provided upon request by any party or the board.

If the utility which has filed for the rate increase is affiliated with another company as either parent or subsidiary, the information required in subparagraphs (3), (4), (6), (13) to (19), and (21) shall be provided for the parent company (if any) and for all affiliates which are not included in the consolidating financial statements filed pursuant to this rule.

(24) Information relating to advertisements including:

1. A portfolio of all advertisements charged to ratepayers either produced, recorded or a facsimile thereof;

2. Cost data for all advertisements and the accounting treatment utilized; and

3. An account of total advertising expense including a breakdown of the expense by category.

f. All rate-regulated utilities shall submit at the time of filing an application for increased rates, all workpapers used to prepare the analysis and data submitted in support of the application. All workpapers shall substantially comply with the standards in 199—subrule 7.10(5).

g. Additional evidence. The applicant may submit any other testimony, schedules, exhibits, and data which it deems pertinent to the application.

(1) Additional evidence may include:

1. Testimony, schedules, exhibits, and data concerning the cost of capital infrastructure investment that will not produce significant revenues and will be in service in Iowa within nine months of the test year.

2. Testimony, schedules, exhibits, and data concerning cost of capital changes that will occur within nine months after the conclusion of the test year that are associated with a new generating plant that has been the subject of a ratemaking principles proceeding pursuant to Iowa Code section 476.53.

(2) The utility shall specifically identify and support the information, including providing an estimate at the time of filing and addressing prudence issues, regarding the changes that will be verifiable within nine months of the test year, with such verification provided to other parties as soon as the data is available. To be considered, the verifiable information must be offered into the record prior to the closing of the record at the hearing in the proceeding.

(3) A utility electing to file additional evidence under this paragraph shall include in the reports required in subparagraph 26.5(5)*"e"*(1) any capital infrastructure investments that will not produce significant revenues and have been placed in service in Iowa, or capital issuances that have been completed that are associated with a new generating plant that has been the subject of a ratemaking principles proceeding pursuant to Iowa Code section 476.53.

(4) A utility electing to file additional evidence under this paragraph shall provide additional schedules as required by subparagraphs 26.5(5)*"e"*(13), (14), and (15) related to capital issuances that have been completed that are associated with a new generating plant that has been the subject of a ratemaking principles proceeding pursuant to Iowa Code section 476.53.

Subparagraphs 26.5(5)*"g"*(1) through (4) are repealed effective July 1, 2007. However, any proceeding that is pending on July 1, 2007, that is being conducted pursuant to Iowa Code section 476.3 or 476.6 shall be completed as if subparagraphs 26.5(5)*"g"*(1) through (4) had not been repealed. Upon repeal of subparagraphs 26.5(5)*"g"*(1) through (4), the board may still consider the adjustments addressed in those subparagraphs, but shall not be required to consider them.

26.5(6) *Evidence requested by the board.* The applicant shall furnish any additional evidence as ordered by the board at any time after the filing of the tariff.

26.5(7) *Applications pursuant to Iowa Code section 476.6 that are not general rate increase applications.* At the time a rate-regulated public utility, other than a rural electric cooperative, files for new or changed rates, charges, schedules, or regulations except in conjunction with general rate increase applications, it shall submit the following:

a. Any cost, revenue, or economic data underlying the filing.

b. An explanation of how the proposed tariff would affect the rates and service of the public utility.

c. All testimony and exhibits in support of the filing attached to affidavits of the sponsoring witnesses.

26.5(8) *Requests for temporary authority pursuant to Iowa Code section 476.6.*

a. A request for temporary authority to place in effect any suspended rates, charges, schedules, or regulations shall be separately identified and shall include:

(1) For each adjustment or issue, a brief explanation of the adjustment or issue and its purpose which includes the specific regulatory principles relied on to support the adjustment or issue and citations to either the rules, statutes, or decisions in which the regulatory principle was codified or previously applied.

(2) Schedules supporting the proposed temporary rate capital structure, schedules showing the calculation of the proposed capital cost for each component of the capital structure, and schedules showing requested return on rate base with capital structure and corresponding capital cost.

(3) All workpapers supporting the request for temporary authority. The workpapers shall substantially comply with the standards in 199—subrule 7.10(5).

b. Within 30 days of the filing of a request for temporary authority, an objection may be filed. An objection to a request for temporary authority shall separately identify each disputed adjustment or issue and shall include:

(1) A brief explanation of the basis for the disputed adjustment or issue which includes the specific regulatory principles relied on and citations to either the rules, the statutes, or decisions in which the regulatory principle was codified or previously applied.

(2) All workpapers supporting the objection to the request for temporary authority. The workpapers shall substantially comply with the standards in 199—subrule 7.10(5).

c. Within 15 days of the filing of the objection, the utility may file a reply.

d. For this rule, the following filing requirements apply:

(1) Request for temporary authority—original plus ten copies.

(2) Objections to request—original plus ten copies.

(3) Replies—original plus ten copies.

(4) Exhibits—original plus ten copies. In addition, two electronic copies of each computer-generated exhibit shall be filed. Only electronic copies of computer-generated exhibits that comply with 199—7.7(476) shall be filed.

(5) Electronic workpapers—two copies and two hard-copy printouts.

(6) Other workpapers—five copies.

(7) Specific studies or financial literature—two copies. In addition, three copies of each document filed shall be provided to consumer advocate.

[Editorial change: IAC Supplement 12/29/10]

199—26.6(476) Answers.

26.6(1) *Time for.* Answers to applications for new or changed rates, charges, schedules, or regulations shall be permitted only if and when the application is docketed as a formal proceeding by the board, and shall be filed with the board within 20 days after the date of docketing. All answers must specifically admit, deny or otherwise answer all material allegations of the pleadings and also briefly set forth the affirmative grounds relied upon to support such answer; except that a party's failure to file an answer to an application for new or changed rates, charges, schedules, or regulations will be deemed a denial of all allegations of the application.

26.6(2) *Motion to dismiss.* Motions to dismiss applications for new or changed rates, charges, schedules, or regulations shall be permitted only if and when the application is docketed as a formal proceeding by the board.

199—26.7(476) Rate investigation. The board shall commence a rate investigation upon the motion of the general counsel or the consumer advocate alleging that a rate-regulated utility's annual report, a special audit, or an investigation by the board staff or the consumer advocate, indicates that the earnings of that public utility may have been or will be excessive. The board may also commence a rate investigation upon the motion of any interested person.

199—26.8(476) Procedural schedule in Iowa Code sections 476.3 and 476.6 proceedings.

26.8(1) In any proceeding initiated as a result of the filing by a public utility of new or changed rates, charges, schedules or regulations, the utilities board or presiding officer shall set a procedural schedule based on the following guidelines, unless otherwise ordered by the utilities board or presiding officer pursuant to this rule. The times and places of consumer comment hearings shall be set at the discretion of the utilities board or presiding officer.

Prepared direct testimony and exhibits in support of the filing—date of initial filing.

Docket case as a formal proceeding, suspend effective date of new or changed rates, charges, schedules or regulations and establish procedural schedule—not later than 30 days from the date of initial filing.

All further testimony—completed not later than six months from date of initial filing.

Cross-examination of all testimony—completed not later than seven months from date of initial filing.

Briefs of all parties—filed not later than eight and one-half months from date of initial filing.

26.8(2) In a proceeding initiated as a result of the filing of a complaint pursuant to Iowa Code section 476.3, the utilities board or presiding officer shall set a procedural schedule based on the following guidelines, unless otherwise ordered by the utilities board or presiding officer pursuant to this rule.

Prepared direct testimony and exhibits in support of the filing—date of initial filing.

Docket case as a formal proceeding to suspend effective date of new or changed rates, charges, schedules or regulations and establish procedural schedule—not later than 30 days from the date of initial filing.

All further testimony—completed not later than six months from date of initial filing.

Cross-examination of all testimony—completed not later than seven months from date of initial filing.

Briefs of all parties—filed not later than eight and one-half months from date of initial filing.

26.8(3) In setting the procedural schedule in a case, the board or administrative law judge shall take into account the existing hearing calendar and shall give due regard to other obligations of the parties, attorneys and witnesses. The board or administrative law judge may on its own motion or upon the motion of any party, including consumer advocate, for good cause shown change the time and place of any hearing. Any effect such a change has on the remainder of the procedural schedule or the deadline for decision shall be noted when the change is ordered.

26.8(4) Additional time may be granted a party, including consumer advocate, upon a showing of good cause for the delay, including but not limited to:

a. Delay of completion of previous procedural step.

b. Delays in responding to discovery or consumer advocate data requests.

Any effect such an extension has on the remainder of the procedural schedule or the deadline for decision shall be noted in the motion for extension and the board order granting the extension.

26.8(5) If any party, including consumer advocate, wishes to utilize the electric generating facility exception to the ten-month decision deadline contained in Iowa Code section 476.6, it shall expeditiously file a motion seeking this exception including an explanation of that portion of the suspended rates, charges, schedules or regulations necessarily connected with the inclusion of the generating facility in rate base. Any other party may file a response to such a motion.

199—26.9(476) Consumer comment hearing in docketed rate case of an investor-owned utility company. The board shall hold consumer comment hearings to provide an opportunity for members of the general public who are customers of an investor-owned utility company involved in a docketed rate case to express their views regarding the case before the board as well as the general quality of service provided by the utility. However, specific service complaints must follow the procedure prescribed in 199—6.2(476). Nothing shall prohibit the board from holding consumer comment hearings on any other docketed rate case.

26.9(1) The consumer comment hearing will be presided over by either the board member(s) or an administrative law judge assigned by the board. Representatives from the utility company shall be

present to explain, in a concise manner, the pertinent points of the company's proposal. The company's representatives shall also respond to any questions directed to them. All representatives from the utility company that are participating, except for legal counsel, shall be under oath. All board staff members that are participating in the hearing shall be under oath.

26.9(2) Individuals who wish to testify at the consumer comment hearing need not preregister with the board but need only sign up at the time of the hearing. The board member(s) or administrative law judge may limit the length of testimony when a large number of persons wish to testify. Sworn testimony shall become a part of the permanent record of the rate proceeding.

26.9(3) All participants in the hearing may correct misinformation within testimony. Correction of misinformation may be made at the time of the hearing during oral presentation or, if the misinformation does not come to the attention of the participants until after the hearing, correction of misinformation may be submitted in writing to the board within 20 days after the oral presentation. Written submissions shall be limited to a statement identifying the party whose testimony is to be corrected, and a brief statement of the incorrect testimony. This shall be followed by a brief statement of the correct information. This procedure shall be utilized to correct only such information that is clearly erroneous. Written submissions of corrections of misinformation shall not be used to slant, clarify or add to the testimony given during oral presentation. Corrections of misinformation which comply with this rule shall become a part of the permanent record.

The consumer comment hearing is not an appropriate forum for any party to make a record for or against the rate case.

26.9(4) The consumer comment hearing shall be held in a major population center served by the utility company at a time of day convenient to the largest number of customers. It shall be conducted in a facility large enough to accommodate all who wish to attend. Notice of the consumer comment hearing shall be sent by the board's public information office to newspapers, radio, and television stations in the area served by the utility company.

26.9(5) Individuals unable to attend a consumer comment hearing may submit written comments to the board. Written comments shall become part of the permanent file of the rate proceeding, but not part of the record as sworn testimony.

26.9(6) Consumer comment hearing may be waived by the board if the interests of the public are better served without a hearing.

This rule is intended to implement Iowa Code sections 474.5, 476.1 to 476.3, 476.6, 476.8, 476.10, 476.31 to 476.33.

199—26.10(476) Appeal from administrative law judge's decision. When an appeal is taken from an administrative law judge's decision determining the reasonableness of rates after formal docketing of the proceeding pursuant to Iowa Code section 476.6, the filing of a notice of appeal in compliance with this rule may be deemed a request for additional time to complete the proceeding, for good cause shown and, if the board so determines, shall extend the date when any rates approved on a temporary basis become permanent for a period not to exceed one-half of the additional time, shown in the procedural schedule, for a final board decision on the appeal.

199—26.11(476) Consideration of current information in rate regulatory proceedings.

26.11(1) Test period. In rate regulatory proceedings under Iowa Code sections 476.3 and 476.6, the board shall consider the use of the most current test period possible in light of existing and verifiable data respecting costs and revenues available as of the date of commencement of the proceedings.

26.11(2) Known and measurable changes. In rate regulatory proceedings under Iowa Code sections 476.3 and 476.6, the board shall consider:

a. Verifiable data, existing as of the date of commencement of the proceedings, respecting known and measurable changes in costs not associated with a different level of revenue and known and measurable revenues not associated with a different level of costs, that are to occur within 12 months after the date of commencement of the proceedings.

b. Data which becomes verifiable prior to the closing of the record at the hearing respecting known and measurable:

(1) Capital infrastructure investments that will not produce significant additional revenues and will be in service in Iowa within nine months after the conclusion of the test year.

(2) Cost of capital changes that will occur within nine months after the conclusion of the test year that are associated with a new generating plant that has been the subject of a ratemaking principles proceeding pursuant to Iowa Code section 476.53.

Verifiable data filed pursuant to paragraph 26.11(2)*"b"* shall be provided to other parties as soon as the data is available so that other parties have a reasonable opportunity to verify the data to be considered by the board.

Paragraph 26.11(2)*"b"* is repealed effective July 1, 2007. However, any proceeding that is pending on July 1, 2007, that is being conducted pursuant to Iowa Code section 476.3 or 476.6 shall be completed as if paragraph 26.11(2)*"b"* had not been repealed. Upon repeal of paragraph 26.11(2)*"b,"* the board may still consider the adjustments addressed in the paragraph, but shall not be required to consider them.

26.11(3) Postemployment benefits other than pensions. For rate-making purposes, the amount accrued for postemployment benefits other than pensions in accordance with Financial Accounting Standard No. 106 will be allowed in rates where:

a. The net periodic postemployment benefit cost and accumulated postemployment benefit obligations have been determined by an actuarial study completed in accordance with the specific methods required and outlined by SFAS No. 106.

b. The accrued postemployment benefit obligations have been funded in a board-approved, segregated and restricted trust account, or alternative arrangements have been approved by the board. Cash deposits shall be made to the trust at least quarterly in an amount that is proportional and, on an annual basis, at least equal to the annual test period allowance for postemployment benefits other than pensions.

c. The transition obligation is amortized over a period of time determined by the board that does not exceed 20 years.

d. Any funds, including income, returned to the utility from the trust not actually used for postemployment benefits other than pensions shall be refunded to customers in a manner approved by the board.

e. The board finds the benefit program and all calculations are prudent and reasonable.

26.11(4) An actuarial study of the net periodic postemployment benefit cost and accumulated postemployment benefit obligations shall be determined and filed with the board at the time a rate increase is requested, when there has been a change in postemployment benefits other than pensions offered by the utility, or every three years, whichever comes first.

26.11(5) For a period not to exceed three years commencing January 1, 1993, a rate-regulated utility may record on its books each year as a deferral the difference between the amount accrued in accordance with SFAS 106 and the amount which would have been recorded for postemployment benefits other than pensions on a pay-as-you-go basis for that year. In calculating the amount to be deferred, the utility may include in the deferral the amortization of transition obligation costs in accordance with SFAS 106.

26.11(6) Recovery of the deferrals authorized in subrule 26.11(5) will be considered only in rate cases filed prior to December 31, 1995.

This rule is intended to implement Iowa Code sections 476.1 to 476.3, 476.6, 476.8, 476.10 and 476.31 to 476.33.

199—26.12(476) Rate regulation election—electric cooperative corporations and associations.

26.12(1) *Application of rules.* Electric cooperative corporations and associations shall not be subject to the jurisdiction of the utilities board except as provided in Iowa Code section 476.1A and paragraphs *"a," "b,"* and *"c"* of this subrule.

a. Procedure for election by members. Upon petition of not less than 10 percent of the members of an electric cooperative or upon its own motion, the board of directors of an electric cooperative shall order a referendum election to be held to determine whether the electric cooperative shall be subject

to the jurisdiction of the utilities board. A petition for election shall be completed within 60 days of commencement.

(1) Any member of an electric cooperative desiring a referendum election shall sign a petition for election addressed to the board of directors of an electric cooperative, in substantially the following form:

PETITION FOR ELECTION

TO: (Board of Directors of subject electric cooperative)

The undersigned members request you call an election to submit to the members the following proposition:

Shall . . . (name of the electric cooperative) be subject to rate regulation by the utilities board?

Signature	Address	Date

(2) Where signatures are made on more than one sheet, each sheet of the petition shall reproduce above the signatures the same matter as is on the first sheet. Each petitioner shall sign their name in their own handwriting and shall write their address and the date on which they signed.

(3) The petition shall be filed with the board of directors of the electric cooperative and an election shall be held not less than 60 days nor more than 90 days from the date on which the petition was filed.

(4) On the election date, the board of directors of the electric cooperative shall mail by first-class mail to each member of the electric cooperative a ballot containing the following language:

Shall . . . (name of the electric cooperative) be subject to rate regulation by the utilities board?

□ Yes □ No

(5) The ballot shall also contain a self-addressed envelope to return the ballot to the secretary of the board of directors of the electric cooperative. The ballot shall be dated when received by the secretary. The ballot must be received by the secretary not more than 30 days after it was mailed to the members. The election procedure shall require a signature form for verification, but shall not allow the signature to be traced to the vote of a particular member.

(6) The issue in the election shall be decided by a majority of the members voting whose ballots are received by the secretary. Fifty-one percent of the membership shall constitute a quorum for the election. The secretary shall certify the results of the election and file the results with the executive secretary of the utilities board within 30 days of the election.

b. Procedure for election by board. Upon the resolution of a majority of the board of directors of an electric cooperative, the board may elect to be subject to the jurisdiction of the utilities board. The secretary of the board of directors of the electric cooperative shall file a certified copy of the resolution with the executive secretary of the utilities board within 30 days of the adoption of the resolution.

c. Effective date. Upon the resolution of a majority of the board of directors of an electric cooperative or when a majority of the members voting vote to place the cooperative under the jurisdiction of the utilities board, the utilities board shall determine an effective date of its jurisdiction which shall be not more than 90 days from the election. On and after the effective date of jurisdiction, the cooperative shall be subject to regulation by the utilities board.

d. Prohibited acts. Funds of an electric cooperative shall not be used to support or oppose the issue presented in the election. Nothing shall prohibit a letter of explanation and direction from being enclosed with the ballot.

e. Procedure for exemption. After the cooperative has been under the jurisdiction of the utilities board for two years, the members may elect to remove the cooperative from under the jurisdiction of the utilities board in the same manner as when electing to be placed under the jurisdiction of the utilities board.

f. Frequency of election. An electric cooperative shall not conduct more than one election pursuant to this subsection within a two-year period.

26.12(2) *Rate increase considerations—rural electric cooperatives.* The board's consideration of the fair and reasonable level of rates necessary for rural electric cooperatives shall include the following:

a. After investigation of the historical test year results and pro forma adjustments thereto, the board shall determine the extent to which the applicant has met the following conditions:

(1) Revenues are sufficient for a times interest earned ratio of from 1.5 to 3.0 for coverage of interest on outstanding utility short-term and long-term debt; or

(2) Revenues are sufficient for a debt service coverage ratio of from 1.25 to 2.50 on utility long-term debt; or

(3) Utility operating margins are sufficient for a ratio of from 1.5 to 2.5 of utility operating margins to interest on utility short-term and long-term debt; or

(4) Utility operating margins are sufficient for a ratio of from 1.25 to 1.75 of utility operating margins plus utility depreciation, all divided by utility long-term interest plus principal; and

(5) Utility operating margins are sufficient to return utility patronage capital credits accumulated from utility operating margins, with a retention of such credits of no more than 20 years allowed, subject to modification where compelling circumstances require time period adjustments.

b. In addition to the information in *"a"* above, evidence of the necessity for the requested rate relief may include, but need not be limited to, utility operating margins which will enable the cooperative to attain and maintain a reasonable ratio of utility long-term debt to retained utility operating margins. Cooperative's authorized construction program and an official policy statement of its board of directors on a desired ratio will be considered factors in the determination of the reasonableness of any such ratio.

c. The utilities board's initial decision will become final 15 days following its date of issuance; however, if filed within that 15-day period, allegations of error by the cooperative, staff or any intervenor as to the utilities board's findings of fact, together with a statement of readiness to present testimony, will serve to hold final disposition in abeyance pending the scheduling and completion of an evidentiary hearing. When such allegation is made, testimony in support of such position must be filed within 30 days of such filing. Upon receipt of the testimony, the utilities board will schedule additional filing dates and set the matter for hearing. When hearing is scheduled, final disposition of the rate proceeding will be accomplished under the contested case provisions of the Iowa administrative procedure Act and the utilities board's rules and regulations thereunder.

These rules are intended to implement Iowa Code sections 474.3, 474.5, 474.6, 476.1 to 476.3, 476.6, 476.8 to 476.10, 476.15, 476.31 to 476.33 and 546.7.

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CHAPTER 37
EQUIPMENT DISTRIBUTION PROGRAM

199—37.1(477C) Policy and purpose. The board has authority under Iowa Code section 477C.4 to plan, establish, administer, and promote a program to secure, finance, and distribute telecommunications devices for the deaf. The needs for equipment to allow persons with communication impairments to use the telephone are not being satisfied in Iowa at this time. A reasonable distribution program is desirable. All customers will benefit when access to the telephone system is available to more persons. The existing dual party relay service will be more fully utilized when more persons have the equipment necessary to gain access to the relay service.

The equipment distribution program will be limited by periodic budget amounts set by the board. When the budgeted amounts for a period are committed or expended, no further vouchers for equipment will be issued until the next period when the board budgets additional amounts.

199—37.2(477C) Program structure. The equipment distribution program will be conducted by a program administrator chosen by the board. Distribution of equipment will be made through a voucher system utilizing private vendors for equipment purchases. Vouchers to pay part or, depending upon the price, all of the cost of equipment will be issued by the program administrator to eligible recipients. After purchase using a voucher, the recipient will be the permanent owner of the equipment and responsible for enforcement of any warranties and for any repairs.

37.2(1) *Amount.* The voucher will state a standard amount for a particular piece of equipment.

a. The standard amount shall be determined and updated periodically by the program administrator.

b. The standard amount shall be 95 percent of the average retail market price for the piece of equipment, unless the retail market price is more than $1,000, in which case the standard amount shall be 99 percent of the average retail market price. The standard amount may be increased to 100 percent if a person demonstrates to the program administrator that the person is unable to pay the matching amount.

37.2(2) *Voucher use.* The recipient of a voucher may purchase equipment from any vendor who will accept the voucher and may apply the voucher amount toward purchase of the brand and model of indicated equipment as the recipient chooses. A bill of sale for equipment purchased prior to the issuance of a voucher shall not be reimbursed.

37.2(3) *Term.* The vouchers shall provide for a 40-day period to present the voucher to the vendor. The vendor, upon presentation of the voucher, shall have 60 days to complete the sale and delivery of the equipment and to return the voucher to the program administrator. The program administrator shall have 20 days to process and return the voucher to the board for payment. The program administrator, for good cause shown, may extend either the 40- or 60-day deadline, provided the voucher is returned to the board for payment within 120 days from the issuance of the voucher. Except for good cause shown, the vendor will not be reimbursed for a voucher issued more than 120 days before the voucher is returned to the board for payment.

37.2(4) *Payment.* The voucher is not a negotiable instrument. Upon presentation of documentation by the vendor as required by the board, including but not limited to a bill of sale showing an amount due no greater than the voucher amount, the vendor will be issued a state warrant for the amount due.

199—37.3(477C) Eligibility. To be eligible to receive a voucher for equipment under the program, a person must satisfy the following standards. Applications will be processed in queue as determined by the program administrator. No person will be entitled to equipment at a particular time merely because that person meets the eligibility requirements. Additional vouchers will not be issued during a period if unpaid vouchers are outstanding for the remaining funds budgeted for the period.

37.3(1) The applicant's need for the equipment must be verified by an appropriate professional, including but not limited to a licensed physician; certified teacher in the fields of hearing, speech, or visual impairment; speech pathologist; audiologist; or an appropriate state or federal agency representative, as part of the initial application. At the time of reapplication for equipment, the applicant must submit

a statement certifying the applicant's condition has not changed to the extent that a different type of equipment is needed. If an applicant's condition has changed to the extent that a different type of equipment is needed from that originally received, the applicant's need must be verified by an appropriate professional.

37.3(2) The applicant must have telephone service available to the applicant's Iowa residence or must have applied for telephone service to the Iowa residence.

37.3(3) The applicant must be an individual.

37.3(4) The applicant must be at least five years of age or demonstrate an ability to use the equipment requested. No demonstration is required for those five years of age and older.

37.3(5) The applicant will be limited to a voucher for one type of equipment or equipment package. If there are individuals in the same household who have different communication impairments that require different types of assistive telecommunications equipment, the individuals may make a joint or separate request to the equipment distribution program administrator. The administrator may grant those portions of the requests that satisfy the eligibility requirements in this rule.

37.3(6) Equipment may be replaced under the program by reapplication as appropriate. Reapplication will be limited by a five-year waiting period. The reapplication period may be shortened by the program administrator for good cause shown.

37.3(7) An applicant must agree to cooperate with studies to evaluate the effectiveness of the program.

37.3(8) An applicant's gross household income must be less than $70,000 for a family of four. Household numbers above or below four will increase or decrease that amount in $8,000 increments.

199—37.4(477C) Equipment. The board will authorize the types of equipment to be distributed through the program, including but not limited to telecommunications devices for the deaf with printers, signalers, amplifiers, computer software, and a limited number of telecommunications devices for the deaf/blind.

199—37.5(477C) Complaints. All complaints concerning the equipment distribution program will be resolved pursuant to the following:

37.5(1) The program administrator will make determinations concerning matters such as eligibility, type of equipment for particular applicants, or reimbursement of vendors.

a. The administrator, after requiring interested persons to state verbally or in writing any complaint or dispute arising under the equipment distribution program, shall attempt to settle the matter informally within 45 days.

b. Should the informal dispute resolution process fail, the complaint may be submitted to the board by the complainant and will be processed by the project manager as provided for utility customers in 199 IAC 6. The complaint will be directed to the program administrator with a copy to the consumer advocate. The board staff assigned to the equipment distribution program will then issue a proposed resolution as defined in 199 IAC 6.4(476).

c. The proposed resolution shall include a description of the facts involved in the dispute and a clear statement of the proposed resolution.

d. The proposed resolution shall also give notice that any interested person dissatisfied with the proposed resolution has 14 days after the issuance of the proposed resolution to file a written request for formal complaint proceedings before the Iowa Utilities Board, 1375 E. Court Avenue, Room 69, Des Moines, Iowa 50319-0069. If no timely request for formal complaint proceedings is filed, the proposed resolution shall be deemed binding on all interested persons served with the proposed resolution. The request for formal complaint proceedings shall be considered as filed on the date of the United States Postal Service postmark or the date personal service is made.

37.5(2) The request for formal complaint proceedings shall explain why the proposed resolution should be modified or rejected and propose an alternate resolution, including any temporary relief desired. Copies of the request shall be mailed to any other persons served with the proposed resolution.

37.5(3) Upon receipt of a request for formal complaint proceedings, the board shall consider whether formal complaint proceedings should be initiated and issue an order. The request shall be granted if the

board determines there is any reasonable ground for investigating the complaint. If the board denies formal complaint proceedings, a party may file a petition for judicial review either in the Polk County district court or in the district court for the county in which the party resides or has its principal place of business.

37.5(4) When a complaint is docketed as a formal proceeding, the procedures set forth in 199—Chapter 7 will apply.

[Editorial change: IAC Supplement 12/29/10]

These rules are intended to implement Iowa Code section 477C.4.

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[Editorial change: IAC Supplement 12/29/10]

CHAPTER 39
UNIVERSAL SERVICE

199—39.1(476) Definition of terms. For the purposes of Universal Service Fund requirements, the following definitions apply:

"Eligible telecommunications carrier" or *"eligible carrier"* means a carrier designated by the board as eligible to receive universal service support pursuant to 47 U.S.C. § 214(e).

"Facilities" means any physical components of the telecommunications network that are used in the transmission or routing of the services designated for Universal Service Fund support.

"Federal Poverty Guidelines" means the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2).

"Toll blocking" means a service that lets consumers elect not to allow the completion of outgoing toll calls from their telecommunications channel.

"Toll control" means a service that allows consumers to specify a certain amount of toll usage that may be incurred on their telecommunications channel per month or per billing cycle.

"Toll limitation" denotes both toll blocking and toll control.

199—39.2(476) Eligible carrier requirements.

39.2(1) *Services required.* Each eligible telecommunications carrier must offer the services supported by the federal Universal Service Fund throughout the approved service area. These services are:

a. Voice grade access to the public switched network. "Voice grade access" is defined as a functionality that enables a user of telecommunications services to transmit voice communications, including signaling the network that the caller wishes to place a call, and to receive voice communications, including receiving a signal indicating there is an incoming call. For purposes of universal service, voice grade access shall occur within the frequency range of between approximately 500 Hertz and 4,000 Hertz, for a bandwidth of approximately 3,500 Hertz;

b. Local usage. "Local usage" means an amount of minutes of use of exchange service, prescribed by the Federal Communications Commission, provided free of charge to end users;

c. Dual tone multifrequency signaling or its functional equivalent. "Dual tone multifrequency (DTMF)" is a method of signaling that facilitates the transportation of signaling through the network, shortening call setup time;

d. Single-party service or its functional equivalent. "Single-party service" is telecommunications service that permits users to have exclusive use of a wireline subscriber loop or access line for each call placed, or, in the case of wireless telecommunications carriers, which use spectrum shared among users to provide service, a dedicated message path for the length of a user's particular transmission;

e. Access to emergency services. "Access to emergency services" includes access to services, such as 911 and enhanced 911, provided by local governments or other public safety organizations. "911" is defined as a service that permits a telecommunications user, by dialing the three-digit code 911, to call emergency services through a Public Service Access Point (PSAP) operated by the local government. "Enhanced 911" is defined as 911 service that includes the ability to provide automatic numbering information (ANI), which enables the PSAP to call back if the call is disconnected, and automatic location information (ALI), which permits emergency service providers to identify the geographic location of the calling party. "Access to emergency services" includes access to 911 and enhanced 911 services to the extent the local government in an eligible carrier's service area has implemented 911 or enhanced 911 systems;

f. Access to operator services. "Access to operator services" is defined as access to any automatic or live assistance to a consumer to arrange for billing or completion, or both, of a telephone call;

g. Access to interexchange service. "Access to interexchange service" is defined as the use of the loop, as well as that portion of the switch that is paid for by the end user, or the functional equivalent of these network elements in the case of a wireless carrier, necessary to access an interexchange carrier's network;

h. Access to directory assistance. "Access to directory assistance" is defined as access to a service that includes, but is not limited to, making available to customers, upon request, information contained in directory listings; and

i. Toll limitation for qualifying low-income consumers. Toll limitation for qualifying low-income consumers includes toll blocking and toll control.

39.2(2) *Additional time to complete network upgrades.* The board may grant the petition of a telecommunications carrier, otherwise eligible to receive universal service support, requesting additional time to complete the network upgrades needed to provide single-party service, access to enhanced 911 service, or toll limitation. If such petition is granted, the otherwise eligible telecommunications carrier will be permitted to receive support for the duration of the period designated by the board. The board will grant such a request only upon a finding that exceptional circumstances prevent an otherwise eligible telecommunications carrier from providing single-party service, access to enhanced 911 service, or toll limitation. The period will extend only as long as the board finds that exceptional circumstances exist and will not extend beyond the time that the board deems necessary for that eligible telecommunications carrier to complete network upgrades. An otherwise eligible telecommunications carrier that is incapable of offering one or more of these three specific universal services must demonstrate to the board that exceptional circumstances exist with respect to each service for which the carrier desires a grant of additional time to complete network upgrades.

39.2(3) *Carrier eligibility requirements.* In addition to providing the services required in 39.2(1), each eligible carrier must:

a. Offer the services required using its own facilities or a combination of its own facilities and resale of another carrier's services. "Own facilities" includes unbundled network elements, in whole or in part. A carrier cannot qualify by providing all of the required services via resale.

b. Advertise the availability of the required services and the charges for the services using media of general distribution to residential customers. Carrier must advertise at least annually, in a publication of general circulation, throughout its approved service area.

c. Submit an explanation of how the carrier will provide each of the supported services listed in 39.2(1).

d. Submit a description, including a detailed map or maps, of the area or areas for which ETC designation is sought. Commercial mobile radio service (CMRS) providers, as defined in 47 CFR Parts 20 and 24, shall file coverage area maps that depict signal strength.

e. Submit a network improvement and maintenance plan associated with the provision of universal supported services. An ETC applicant shall submit a two-year plan specifically describing its proposed network improvements, upgrades, and maintenance for its proposed designated service area. The plan must demonstrate in detail how high-cost support will be used for service improvements or maintenance that would not occur absent support. The plan must demonstrate: (1) how signal quality, coverage, or capacity will improve in the designated area due to receipt of support; (2) the projected start date and completion date for each improvement, including the estimated amount of investment per project funded by high-cost support; (3) the specific geographic areas where improvements will be made; and (4) the estimated population that will be served as a result of the improvements. This information shall identify the benefits to specific wire centers in the carrier's proposed designated service area. Carriers that are not requesting high-cost support shall indicate this in their applications. Carriers that are not seeking or receiving high-cost support are not required to file network improvement and maintenance plans, nor are they required to file annual extensions and progress reports.

f. Demonstrate compliance with applicable consumer protection standards. Wireline ETC applicants shall commit to complying with the consumer protection rules set out in 199—Chapters 6 and 22. Wireless ETC applicants shall commit to complying with the following minimum consumer protection standards:

(1) Provide disclosure rates and terms of service to consumers. For each rate plan offered to new consumers, wireless carriers shall make available to consumers in collateral or other disclosures at point of sale and on their Web sites, at a minimum, the following information, as applicable:

1. The calling area for the plan;

2. The monthly access fee or base charge;
3. The number of airtime minutes included in the plan;
4. Any night and weekend minutes included in the plan or other differing charges for different time periods and the time periods when night and weekend minutes or other charges apply;
5. The charges for excess or additional minutes;
6. Per-minute long distance charges or whether long distance is included in other rates;
7. Per-minute roaming or off-network charges;
8. Whether any additional taxes, fees or surcharges apply;
9. The amount or range of any such fees or surcharges that are collected and retained by the carrier;
10. Whether a fixed-term contract is required and, if so, its duration;
11. Any activation or initiation fee; and
12. Any early termination fee that applies and the trial period during which no early termination fee will apply.

(2) Make available maps showing where service is generally available. Wireless carriers shall make available at point of sale and on their Web sites maps depicting approximate voice service coverage applicable to each of their rate plans currently offered to consumers. To enable consumers to make comparisons among carriers, these maps shall be generated using generally accepted methodologies and standards to depict outdoor coverage. All such maps shall contain an appropriate legend concerning limitations and variations in wireless coverage and map usage, including any geographic limitations on the availability of any services included in the rate plan. Wireless carriers shall periodically update such maps as necessary to keep the maps reasonably current. If necessary to show the extent of service coverage available to customers from carriers' roaming partners, carriers shall request and incorporate roaming partners' coverage maps that are generated using similar industry-accepted criteria or, if such information is not available, incorporate publicly available information regarding roaming partners' coverage areas.

(3) Provide contract terms to customers and confirm changes in service. When a customer initiates service with a wireless carrier or agrees to a change in service whereby the customer is bound to a contract extension, the carrier shall provide or confirm the material terms and conditions of service with the customer.

(4) Allow a trial period for new service. When a customer initiates service with a wireless carrier, the customer shall be informed of and given a period of not less than 14 days to try out the service. The carrier shall not impose an early termination fee if the customer cancels service within this period, provided that the customer complies with applicable return and exchange policies. Other charges, including airtime usage, may still apply.

(5) Provide specific disclosure in advertising. In advertising of prices for wireless service or devices, wireless carriers shall disclose material charges and conditions related to the advertised prices, including if applicable and to the extent the advertising medium reasonably allows:

1. Activation or initiation fees;
2. Monthly access fees or base charges;
3. Any required contract term;
4. Early termination fees;
5. The terms and conditions related to receiving a product or service for "free";
6. The times of any peak and off-peak calling periods;
7. Whether different or additional charges apply for calls outside the carrier's network or outside designated calling areas;
8. For any rate plan advertised as "nationwide" (or using a similar term), the carrier shall have available substantiation for this claim;
9. Whether prices or benefits apply only for a limited time or promotional period and, if so, any different fees or charges to be paid for the remainder of the contract term;
10. Whether any additional taxes, fees, or surcharges apply; and
11. The amount or range of any such fees or surcharges collected and retained by the carrier.

(6) Separately identify carrier charges from taxes on billing statements. On customers' bills, the carrier shall distinguish monthly charges for service and features and other charges collected and retained by the carrier from taxes, fees, and other charges collected by the carrier and remitted to federal, state, or local governments. Carriers shall not label cost recovery fees or charges as taxes.

(7) Provide customers the right to terminate service for changes to contract terms. Carriers shall not modify the material terms of their subscribers' contracts in a manner that is materially adverse to subscribers without providing a reasonable advance notice of a proposed modification and allowing subscribers a time period of not less than 14 days to cancel their contracts with no early termination fee.

(8) Provide ready access to customer service. Customers shall be provided a toll-free telephone number to access a carrier's customer service department during normal business hours. Customer service contact information shall be provided to customers on line and on billing statements. Each wireless carrier shall provide information about how customers may contact the carrier in writing, by toll-free telephone number, via the Internet, or otherwise with any inquiries or complaints, and this information shall be included, at a minimum, on all billing statements, in written responses to customer inquiries, and on carriers' Web sites. Each carrier shall also make such contact information available, upon request, to any customer calling the carrier's customer service department.

(9) Promptly respond to consumer inquiries and complaints received from government agencies. Inquiries for information or complaints to a wireless ETC shall be resolved promptly and courteously. If a wireless ETC cannot resolve a dispute with the applicant or customer, the wireless ETC shall inform the applicant or customer of the right to file a complaint with the board. The wireless ETC shall provide the following board address and toll-free telephone number: Iowa Utilities Board, Customer Service, 1375 E. Court Avenue, Room 69, Des Moines, Iowa 50319-0069; 1-877-565-4450. When the board receives a complaint, the procedures set out in 199—Chapter 6, "Complaint Procedures," shall be followed to enforce the minimum consumer protection standards in paragraph 39.2(3)*"f."* When the board receives a complaint alleging the addition or deletion of a product or service for which a separate charge is made to a customer account without the verified consent of the customer, the complaint shall be processed by the board pursuant to 199—Chapter 6. In any complaint proceeding pursuant to this subparagraph, if the wireless ETC asserts that the complainant is located in an area where the wireless ETC is not designated as an ETC, the wireless ETC must submit evidence in support of its assertion.

(10) Abide by policies for protection of customer privacy. Each wireless ETC shall abide by a policy regarding the privacy of customer information in accordance with applicable federal and state laws and shall make available to the public its privacy policy concerning information collected on line.

g. Demonstrate compliance with applicable service quality standards. Wireline ETC applicants shall demonstrate that they will comply with applicable service quality standards set forth in 199—Chapter 22. All ETC applicants shall commit to complying with the service quality reporting requirements set forth in 199—39.5(476).

h. Certify the ability to maintain a minimum of two hours of backup power to ensure functionality without an external power source.

i. Demonstrate a commitment to offer a local usage plan comparable to the one offered by the incumbent local exchange carrier in the areas for which the carrier seeks designation. ETC applicants shall commit to providing Lifeline and Link-Up consistent with 47 CFR 54.401 and 47 CFR 54.411.

j. File a statement that the carrier acknowledges that the FCC may require it to provide equal access if all other eligible carriers in its ETC designated service area relinquish their designations pursuant to Section 214(e) of the Telecommunications Act of 1996.

k. When the ETC applicant seeks to provide service in a rural area, demonstrate that granting ETC designation is in the public interest. The public interest analysis shall include discussion of the benefits of increased consumer choice and, if relevant, of the benefits of providing consumer choices on service offerings in rural and high-cost areas. The public interest analysis shall also include discussion of the particular advantages and disadvantages of the applicant's offering. For example, the analysis may discuss the potential benefits of mobility that wireless carriers provide in geographically isolated areas, the potential impact on toll charges to affected consumers, and the potential for consumers to obtain services such as voicemail, numeric paging, call forwarding, three-way calling, call waiting, and

other premium services comparable to those provided in urban areas. The analysis shall also address the disadvantages of dropped-call rates and poor coverage.

l. Respond to board requests for information related to the status of local voice service markets or facilities. Board requests may include requests for surveys on the number of customers using specific services, facilities, or service packages and explanations of services or service packages, pricing on services offered, carrier advertising efforts, and market trends.

39.2(4) *Determination of eligibility.* Eligibility to receive support from the Universal Service Fund must be obtained from the board. To be designated an eligible carrier, a carrier must file a request using the form that appears in this subrule.

IOWA DEPARTMENT OF COMMERCE
UTILITIES BOARD

REQUEST FOR UNIVERSAL SERVICE
ELIGIBLE CARRIER STATUS IN IOWA

This form is to be completed by the petitioning Carrier and returned to the Board. This form is intended to enable compliance with 199 IAC 39.2(4).

1. FULL NAME OF CARRIER PROVIDING SERVICE IN IOWA:

_____

CARRIER MAILING ADDRESS:

_____

_____

_____

NAME, TITLE AND TELEPHONE NUMBER OF CONTACT PERSON:

_____

_____

_____

_____CHECK HERE IF CARRIER HEREBY CERTIFIES THAT IT OFFERS THE SERVICES DESIGNATED FOR UNIVERSAL SUPPORT AS LISTED AND DEFINED IN 199 IAC 39.2(1).

_____CHECK HERE IF CARRIER SEEKS ADDITIONAL TIME TO COMPLETE NETWORK UPGRADES UNDER THE PROVISIONS OF 199 IAC 39.2(2). THE CARRIER PETITION FOR ADDITIONAL TIME SHOULD BE INCLUDED AS AN ATTACHMENT TO THIS FORM. CARRIER CERTIFIES THAT IT OFFERS THE SERVICES LISTED IN 199 IAC 39.2(1) OTHER THAN THOSE FOR WHICH ADDITIONAL TIME IS SOUGHT.

2. CARRIER USES ITS OWN FACILITIES TO PROVIDE SERVICES SUPPORTED BY UNIVERSAL SERVICE FUND OR PROVIDES THE SERVICES BY A COMBINATION OF ITS OWN FACILITIES AND RESALE OF ANOTHER CARRIER'S SERVICE(S). "OWN FACILITIES" IS DEFINED IN 199 IAC 39.2(3)*"a."*

3. CARRIER WILL ADVERTISE AT LEAST ANNUALLY THE AVAILABILITY OF SERVICES DESIGNATED FOR UNIVERSAL SERVICE SUPPORT AND THE CHARGES THEREFOR USING MEDIA OF GENERAL DISTRIBUTION.

4. _____CHECK HERE IF CARRIER IS NOT CURRENTLY APPROVED TO PROVIDE LOCAL SERVICE. IF CHECKED, PLEASE INCLUDE WITH THE FILING OF THIS REQUEST DOCUMENTATION SHOWING YOUR SERVICE AREA.

ATTESTATION

I,_____, certify that I am the company officer responsible for this request, that I have examined the foregoing request, and that to the best of my knowledge, information, and belief all statements of fact contained in the request are correct statements of the business and affairs of the applicant with respect to each and every matter set forth.

Dated ____/____/____

Telephone Number (_____)_____-_____

SIGNATURE _____

39.2(5) *Area served.*

a. Unless otherwise ordered by the board, the approved service area for Universal Service Fund support calculations will be the same as the service area currently approved for local service by the board. Those carriers not currently approved to provide local service are required to provide documentation showing their service area.

b. In the case of a service area served by a rural telephone company, "service area" means such company's "study area" unless and until the Commission and the states, after taking into account recommendations of a Federal-State Joint Board instituted under Section 410(c) of the Act, establish a different definition of service area for such company.

c. In the case of a wireless telecommunications carrier, "service area" means that area where the wireless company has been licensed by the FCC to provide service.

(1) If the application of 39.2(5)*"c"* and the service requirement of 39.2(1) pose an undue hardship on a wireless telecommunications carrier seeking designation as an eligible telecommunications carrier, a wireless carrier may request a waiver of 39.2(1), pursuant to 199—1.3(17A,474,476,78GA,HF2206).

(2) Requests by a wireless telecommunications carrier for a waiver of 39.2(1) must state, in addition to the requirements established in 199—1.3(17A,474,476,78GA,HF2206), the extent of the area in which the carrier is licensed by the FCC to provide service, the extent of the area in which the carrier is seeking designation, and the carrier's ability to expand universal service fund-supported services throughout its licensed service area within a reasonable time frame. A request for a waiver under 39.2(5)*"c"* must also include a statement that, should a wireless carrier receive a request from a potential customer within its service area but outside its existing network coverage, the wireless carrier will take a number of steps to provide service to that customer which may include modification or replacement of the requesting customer's equipment, deployment or installation of a roof-mounted antenna or other equipment necessary to provide service, cell tower adjustments, network or customer facility adjustments, an offer of resold services from another carrier's facilities to provide service, or the employment or construction of an additional cell site, cell extender or repeater.

39.2(6) *Location of facilities.* The facilities providing the services supported by the universal fund need not be physically located in the area served.

39.2(7) *Previously designated ETCs.* Any carrier that was designated by the board as an ETC before November 29, 2006, and that receives high-cost universal service support pursuant to applicable federal regulations governing high-cost support shall file a statement demonstrating compliance with the requirements in 39.2(3)*"d"* through *"j"* on or before March 1, 2007. As part of this filing, each ETC shall file a network improvement and maintenance plan for a reporting period of January 1, 2007, through December 31, 2008. Each carrier shall also acknowledge that it will respond to board requests for information related to the status of local voice service markets or facilities as required by 39.2(3)*"l."* A wireline ETC that has service area maps on file with the board, or that adopts such maps before November 29, 2006, does not need to refile the service area maps as would otherwise be required by 39.2(3)*"d."*

[Editorial change: IAC Supplement 12/29/10]

199—39.3(476) Low-income connection assistance program (Link-Up) and low-income Lifeline assistance.

39.3(1) *Filing of tariffs or inclusion of offer in contracts.*

a. Eligible telecommunications carriers that file tariffs with the board shall include in their tariffs provisions offering low-income connection assistance (Link-Up) and low-income Lifeline assistance rates to qualified applicants for single-party service, voice grade access to the public switched network, DTMF (Dual Tone Multi-Frequency) or its functional digital equivalent, access to emergency services, access to operator services, access to interexchange service, and access to directory assistance. In addition, toll limitation shall be included in this service offering without charge to the Lifeline customer.

b. Eligible carriers that do not file tariffs with the board shall include the Link-Up and Lifeline offerings in their agreements to provide service to customers. These eligible carriers shall file with the board copies of their current customer service agreements.

39.3(2) *Rates.*

a. Link-Up connection assistance rates. The reduced rates shall include all state-tariffed connection charges for installing basic residential service except security deposits. The eligible carrier shall offer to qualified applicants either or both of the following:

(1) A reduction of 50 percent of all connection charges or $30, whichever is less, and

(2) A deferred payment schedule of equal payments of the charges of up to $200 assessed for commencing service. The consumer does not pay interest on the deferred charges. The deferral period shall not exceed one year.

(3) The consumer shall receive the benefit of the Link-Up program for a second or subsequent time only for a principal place of residence with an address different from the residence address at which Link-Up assistance was provided previously.

b. Lifeline assistance rates. The rates charged to qualified applicants shall reflect the following:

(1) Eligible carriers that charge federal end-user common line charges or equivalent federal charges must apply the federal baseline Lifeline support to waive the Lifeline consumer's federal end-user common line charges.

(2) Eligible carriers that do not charge federal end-user common line charges or equivalent federal charges must apply the federal baseline Lifeline support amount to reduce the Lifeline consumer's lowest tariffed residential rate.

(3) Qualified applicants shall have their monthly local exchange service rate reduced by the federal support of $1.75, in addition to the baseline federal support used either to waive the Lifeline consumer's federal end-user common line charges, or to reduce the Lifeline consumer's residential rate.

(4) Eligible carriers may not collect a service deposit in order to initiate Lifeline service, if the qualified applicant voluntarily elects toll blocking where available.

39.3(3) *Qualified applicants.* To be eligible for Lifeline or Link-Up assistance, an applicant must either have income that is at or below 135 percent of the Federal Poverty Guidelines or participate in one of the following programs:

a. Medicaid (e.g., Title XIX/Medical, state supplemental assistance);
b. Food stamps;
c. Supplemental Security Income;
d. Federal Public Housing Assistance Section 8;
e. Low-income Home Energy Assistance Program;
f. Temporary Assistance to Needy Families;
g. National School Lunch Program's free lunch program.

39.3(4) *Certification.* The certification of eligibility for Lifeline or Link-Up rate assistance shall be upon a form as set forth below. The form shall be supplied to the applicant by the eligible carrier.

LINK-UP AND LIFELINE RATE ASSISTANCE CERTIFICATION

Name_____ SSN_____

Address_____

_____

_____

City State Zip

Phone Number where you may be reached or receive messages (_____)_____

Please answer the following questions (indicate by check mark):

1. By filling out this application I (the applicant) request:

___Low-income telephone connection assistance (Link-Up) and/or

___Low-income telephone Lifeline assistance.

2. Have you received Link-Up assistance at the above address in the past?

___Yes
___No
If the answer is "yes," you are not eligible for Link-Up assistance.
3. Are you participating in any of the following programs?
___Medicaid (e.g., Title XIX/Medical, State Supplemental Assistance)
___Food Stamps
___Supplemental Security Income
___Federal Public Housing Assistance Section 8
___Low-Income Home Energy Assistance
___Temporary Assistance to Needy Families program
___National School Lunch Program's free lunch program
4. Is your income at or below 135 percent of the Federal Poverty Guidelines?
___Yes
___No

I understand completion of this application does not constitute immediate acceptance into these programs. I agree to notify the telecommunications carrier if I cease to participate in any of the public assistance programs I checked above or if my income becomes greater than 135 percent of the Federal Poverty Guidelines.

I certify under penalty of perjury the above information is true. I have read the information on this application and understand I must meet the above qualifications to receive assistance from these programs.

SIGNATURE_____ DATE_____

39.3(5) *Data collection.* Eligible carriers shall keep records of the number of subscribers receiving Link-Up and Lifeline assistance. Each eligible carrier must keep accurate records of the revenues it forgoes in providing Lifeline and Link-Up. The board requires that the carrier file information with the federal administrator demonstrating the carrier's Lifeline and Link-Up plans meet the federal criteria, indicating the number of qualifying low-income consumers, and stating there are no state contributions.

In addition, eligible carriers shall mail each year to Lifeline and Link-Up subscribers the verification form set out below (or another form that requests the same information), in a sample size consistent with the formulas and table set forth in Appendix J of In the Matter of Lifeline and Link-Up, Report and Order and Further Notice of Proposed Rulemaking, WC Docket No. 03-109, Release No. 04-87, 199 FCC Rcd 8302 (April 29, 2004). Subscribers who receive the verification form should be selected at random. Eligible carriers shall then verify on their annual report that they have performed the required verification.

LINK-UP AND LIFELINE RATE ASSISTANCE VERIFICATION

Failure to return this verification within 30 days may cause you to no longer be eligible for this subsidy.

Name_____ SSN_____

Address_____

_____

_____

City State Zip

I am currently receiving low-income monthly telephone bill assistance (Lifeline) at the following:

Phone Number:_____

Address:_____

I am currently participating in the following program(s):

___Medicaid (e.g., Title XIX/Medical, State Supplemental Assistance);

___Food Stamps;
___Supplemental Security Income;
___Federal Public Housing Assistance Section 8;
___Low-Income Home Energy Assistance;
___Temporary Assistance to Needy Families program;
___National School Lunch Program's free lunch program; or
___My income is at or below 135 percent of the Federal Poverty Guidelines.

I agree to notify the telecommunications carrier if I cease to participate in any of the public assistance programs I checked above or if my income becomes greater than 135 percent of the Federal Poverty Guidelines.

I certify under penalty of perjury the above information is true. I have read the information on this application and understand I must meet the above qualifications to receive assistance from these programs.

SIGNATURE_____DATE_____

39.3(6) *Customer notification.*

a. Eligible carriers shall inform all persons ordering new or transferring existing residential service of the Link-Up and Lifeline assistance programs and shall inquire whether the customer wants to have further information concerning the programs provided, unless it is apparent that the customer would not be eligible.

b. The eligible carrier shall provide informational brochures and application forms to the county offices of the Iowa department of human services, division of community services for the counties served, to the area agency on aging, and to the community action offices of the department of human rights for the region served. In counties or regions served by more than one eligible carrier, the carriers are encouraged to cooperate in providing the brochures and forms jointly.

c. The eligible carriers shall pursue media coverage of the Link-Up and Lifeline assistance programs. This may include advertising where appropriate.

199—39.4(476) Universal service support for schools and libraries. With respect to intrastate telecommunication services, determined by either the board or the Federal Communications Commission to be within the definition of universal service, the discount for elementary schools, secondary schools, and libraries shall be equal to the discount the Federal Communications Commission sets with respect to interstate service.

199—39.5(476) Quality of service reporting by eligible telecommunications carriers. Carriers designated by the utilities board as eligible to receive high-cost universal service support pursuant to 47 U.S.C. § 214(e) and that receive such support must measure and report to the board the quality of service performance for the criteria listed below. The first service quality reports on the criteria in subrules 39.5(1) through 39.5(7) shall be filed by August 1, 2007, and shall cover a reporting period of January 1 through June 30, 2007. The next service quality reports shall be filed by May 1, 2008, and shall cover a reporting period of July 1 through December 31, 2007. Beginning with the reports due on May 1, 2009, and for subsequent reports due on May 1 of each year, the reporting period shall cover the preceding calendar year.

39.5(1) Local usage. The amount of minutes of service provided each month, without any additional charge, as part of the ETC-eligible service. Each ETC shall include a description of its rate plans; a definition of the calling area associated with the plans; an explanation of bundling of local and long distance services; an explanation of free calls to government agencies or other entities; and an explanation of other issues related to the rates and terms of the plans.

39.5(2) Access to emergency services. A listing of each area in Iowa where the eligible carrier currently provides Phase I and Phase II E-911.

39.5(3) Answer time. The average wait time experienced by customers when calling an ETC's customer service center, regardless of the locations from which the customers were calling.

39.5(4) Retail locations. The number, location, hours of service, and telephone number for each carrier-owned retail location in Iowa, as well as the eligible carrier's Web address and toll-free customer service number.

39.5(5) FCC outage reports. Each ETC shall file with the board copies of all FCC outage reports it filed with the FCC. The copies will be filed as confidential pursuant to the provisions of 199—paragraph 1.9(5)*"c."*

39.5(6) The number of requests for service from potential customers that were unfilled for over five days during the past year.

39.5(7) The number of complaints per 1000 handsets or lines. ETCs serving fewer than 1000 handsets or access lines shall report the actual number of complaints.

39.5(8) Extensions of network improvement and maintenance plans. On or before May 1 of each year, each ETC shall file a rolling one-year extension of its network improvement and maintenance plan. The initial rolling one-year extension shall report improvements and maintenance planned for calendar year 2009 and shall be filed by May 1, 2008.

39.5(9) Progress reports on network improvement and maintenance plans. On or before May 1, 2008, and each May 1 thereafter, each ETC shall file a progress report on its network improvement and maintenance plan detailing the prior calendar year's activities. The progress report shall include coverage area maps detailing progress toward plan targets, an explanation of how much universal service support was received, and how the support was used to improve signal quality, coverage, or capacity. If support was used for something other than improving signal quality, coverage, or capacity, the report shall include an explanation of how the support was used. The report shall identify any network improvement targets that have not been met and shall include an explanation of why targets were not met. The report shall indicate if there have not been any changes to the ETC's coverage area and shall include an explanation of why no changes were made. Any reporting of expense and investment information shall include an explanation of how the expenses and investments benefited specific wire centers in the ETC's designated service area. For purposes of this subrule, "wire center" shall be defined as determined by the North American Numbering Plan Administrator.

199—39.6(476) Universal service certification.

39.6(1) *Certification to be filed with the board.* Any carrier desiring to continue to receive federal high-cost universal service support shall file with the board no later than May 1 of each year an original and two copies of an affidavit and shall file one copy with the consumer advocate division of the department of justice.

39.6(2) *Content of certification.* Each affidavit shall be titled "Certification of [Company Name]." The company name shall be the same name shown on the carrier's tariff as filed with the board. If the ETC does not file tariffs with the board, the ETC shall provide the name used on its initial application for ETC designation and its current name, if its name has changed. The affidavit shall include the study area code (SAC) number associated with the company. The affidavit shall be sworn and notarized and shall be executed by an authorized corporate officer. The affidavit shall certify that the carrier will use the support the carrier receives pursuant to FCC regulations or successor regulations concerning high-cost universal service support only for the provision, maintenance, and upgrading of facilities and services for which the support is intended. In addition, the affidavit shall certify that the carrier will comply with applicable service quality standards and consumer protection rules, certify that the carrier is able to maintain backup power for a minimum of two hours to ensure functionality without an external power source, certify that the carrier is offering a local usage plan comparable to that offered by the ILEC in the relevant service areas, and certify that the carrier acknowledges that the FCC may require it to provide equal access to long distance carriers in the event that no other eligible carrier is providing equal access within the ETC's designated service area. The affidavit shall also certify to the following: As an eligible telecommunications carrier, the carrier agrees to provide timely responses to board requests for information related to the status of local voice service markets or facilities.

39.6(3) *Certifications subject to complaint or investigation.* Any certification filed by a carrier shall be subject to complaint or investigation or both by the board.

CERTIFICATION OF [COMPANY NAME]

STATE OF IOWA
COUNTY OF _____

I, [authorized corporate officer], [office], [company name], being of lawful age and duly sworn, depose and state:

[Company name], [SAC number], will use the support [company name] received pursuant to 47 CFR §§ 54.301, 54.305, or 54.307, or Part 36, Subpart F, of FCC regulations or successor regulations concerning high-cost universal service support, only for the provision, maintenance, and upgrading of facilities and services for which the support is intended. In addition, [company name] certifies that it will comply with applicable service quality standards and consumer protection rules, certifies that it is able to maintain a minimum of two hours of backup power to ensure functionality without an external power source, certifies that it is offering a local usage plan comparable to that offered by the ILEC in the relevant service areas, and certifies that it acknowledges that the FCC may require it to provide equal access to long distance carriers in the event that no other eligible carrier is providing equal access, within [company name's] ETC designated service area. As an eligible telecommunications carrier, [company name] agrees to provide timely responses to board requests for information related to the status of local voice service markets or facilities.

I further state that I am authorized by [company name] to make this statement.

_____

[authorized officer]

Subscribed and sworn to before me this _____ day of _____, _____.

_____

Notary Public

These rules are intended to implement Iowa Code section 476.102 and the Telecommunications Act of 1996, 47 U.S.C. § 214 and 254.

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HUMAN SERVICES DEPARTMENT[441]

Rules transferred from Social Services Department[770] to Human Services Department[498], see 1983 Iowa Acts, Senate File 464, effective July 1, 1983.
Rules transferred from agency number [498] to [441] to conform with the reorganization numbering scheme in general, IAC Supp. 2/11/87.

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EMERGENCY ASSISTANCE

DIVISION I
IOWA DISASTER AID INDIVIDUAL ASSISTANCE GRANT PROGRAM

PREAMBLE

This division implements a state program of financial assistance to meet disaster-related expenses, food-related costs, or serious needs of individuals or families who are adversely affected by a state-declared disaster emergency. The program is intended to meet needs that cannot be met by other means of financial assistance.

441—58.1(29C) Definitions.

"Emergency management coordinator" means the person appointed by the local emergency management commission pursuant to Iowa Code sections 29C.9 and 29C.10 to be responsible for development of the countywide emergency operations plan and for coordination and assistance to government officials when an emergency or disaster occurs.

"Household" means all adults and children who lived in the pre-disaster residence who request assistance, as well as any persons, such as infants, spouses, or part-time residents, who were not present at the time of the disaster but who are expected to return during the assistance period.

"Necessary expense" means the cost associated with acquiring an item or items, obtaining a service, or paying for any other activity that meets a serious need.

"Safe, sanitary, and secure" means free from disaster-related health hazards.

"Serious need" means the item or service is essential to the household to prevent, mitigate, or overcome a disaster-related hardship, injury, or adverse condition.

441—58.2(29C) Program implementation.

58.2(1) *Disaster declaration.* The Iowa individual assistance grant program (IIAGP) shall be implemented when the governor issues a declaration of a state of disaster emergency that authorizes individual assistance. The program shall be in effect only in those counties named in the declaration. Assistance shall be provided for a period not to exceed 120 days from the date of declaration.

58.2(2) *Voucher system.* To implement a voucher system for IIAGP, the county board of supervisors shall authorize a local administrative entity to administer the system.

a. The local administrative entity may be, but is not limited to:

(1) A local community organization active in disaster (COAD),

(2) A local long-term recovery committee (LTRC),

(3) A nonprofit organization,

(4) A faith-based organization, or

(5) A regional or statewide LTRC.

b. The local administrative entity shall enter into a contract with the department of human services using Form FA 09-15-2010, Fiscal Agent Contract. The contract shall specify the terms for the administration of IIAGP benefits through a voucher system.

[**ARC 9128B**, IAB 10/6/10, effective 10/1/10; **ARC 9312B**, IAB 12/29/10, effective 3/1/11]

441—58.3(29C) Application for assistance. To request assistance for disaster-related expenses, the household shall complete Form 470-4448, Individual Disaster Assistance Application, and submit it within 45 days of the disaster declaration to the county emergency management coordinator along with: (1) receipts for the claimed expenses or (2) a request to participate in a voucher system.

58.3(1) Application forms are available from county emergency management coordinators and local offices of the department of human services, as well as the Internet Web site of the department at www.dhs.iowa.gov.

58.3(2) The application shall include:

a. A declaration of the household's annual income, accompanied by:

(1) A current pay stub, W-2 form, or income tax return, or

(2) Documentation of current enrollment in an assistance program administered by the department of human services, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), or other subsidy program.

b. A release of confidential information to personnel involved in administering the program.

c. A certification of the accuracy of the information provided.

d. An assurance that the household had no insurance coverage for claimed items.

e. A commitment to refund any part of a grant awarded that is duplicated by insurance or by any other assistance program, such as but not limited to local community development groups and charities, the Small Business Administration, or the Federal Emergency Management Administration.

f. A short, handwritten narrative of the disaster event and how the disaster caused the loss being claimed.

g. A copy of a picture identification document for each adult applicant.

h. When vehicle damage is claimed, current copies of the vehicle registration and liability insurance card.

[**ARC 9128B**, IAB 10/6/10, effective 10/1/10; **ARC 9312B**, IAB 12/29/10, effective 3/1/11]

441—58.4(29C) Eligibility criteria. To be eligible for assistance, an applicant household must meet all of the following conditions:

58.4(1) The household's residence was located in the area identified in the disaster declaration during the designated incident period and the household verifies occupancy at that residence.

58.4(2) Household members are citizens of the United States or are legally residing in the United States.

58.4(3) The household's self-declared annual income is at or less than 200 percent of the federal poverty level for a household of that size.

a. Poverty guidelines are updated annually.

b. All income available to the household is counted, including wages, child support, interest from investments or bank accounts, social security benefits, and retirement income.

58.4(4) The household has disaster-related expenses or serious needs that are not covered by insurance or the claim is less than the deductible amount. This program will not reimburse the amount of the insurance deductible when the claim exceeds the deductible amount.

58.4(5) The household has not previously received assistance from this program or another program for the same loss.

441—58.5(29C) Eligible categories of assistance. The maximum assistance available to a household in a single disaster is $5,000. Assistance is available under the program for the following disaster-related expenses:

58.5(1) Assistance may be issued for personal property, including repair or replacement of the following items, based on the item's condition:

a. Kitchen items, up to a maximum of $560, including:

(1) Equipment and furnishings, up to a maximum of $560.

(2) Food, up to a maximum of $50 for one person plus $25 for each additional person in the household.

b. Personal hygiene items, up to a maximum of $30 per person and $150 per household.

c. Clothing and bedroom furnishings, up to a maximum of $875, including:

(1) Mattress, box spring, frame, and storage containers, up to a maximum of $250 per person.

(2) Clothing, up to a maximum of $145 per person.

d. Other items, including:

(1) Infant car seat, up to a maximum of $40.

(2) Dehumidifier, up to a maximum of $150.

(3) Sump pump (in a flood event only), up to a maximum of $200 installed.

(4) Electrical or mechanical repairs, up to a maximum of $1,000.

(5) Water heater, up to a maximum of $425 installed.

(6) Vehicle repair, up to a maximum of $500.

(7) Heating and air-conditioning systems, up to a maximum of $2,100 installed. Air conditioning is covered only with proof of medical necessity.

58.5(2) Assistance may be issued for home repair as needed to make the home safe, sanitary, and secure, up to a maximum of $5,000.

a. Assistance will be denied if preexisting conditions are the cause of the damage.

b. Assistance may be authorized for:

(1) The repair of structural components, such as the foundation and roof.

(2) The repair of floors, walls, ceilings, doors, windows, and carpeting of essential interior living space that was occupied at the time of the disaster.

(3) Debris removal, including trees, up to a maximum of $1,000.

c. Repairs to rental property are excluded under this program.

58.5(3) Assistance may be issued for temporary housing assistance, up to a limit of $50 per day, for lodging at a licensed establishment, such as a hotel or motel, if the household's home is destroyed, uninhabitable, inaccessible, or unavailable to the household.

[**ARC 9312B**, IAB 12/29/10, effective 3/1/11]

441—58.6(29C) Eligibility determination and payment.

58.6(1) The county emergency management coordinator or designee shall:

a. Confirm that:

(1) The address provided on the application is a valid address and is reasonably believed to be in the disaster-affected area, and

(2) Disaster-related expenses were possible as a result of the current disaster.

b. If receipts are included, submit the household's application form and receipts to the Homeland Security and Emergency Management Division, Camp Dodge, Building W-4, 7105 NW 70th Avenue, Johnston, Iowa 50131. The envelope shall be marked "IIAGP application."

c. If the applicant requests to participate in the voucher system, forward the application to the local administrative entity for the county.

58.6(2) For applications with receipts:

a. The homeland security and emergency management division of the department of public defense shall:

(1) Review the application.

(2) Submit the household's application form and receipts to the DHS Office of the Deputy Director for Administration, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. The envelope shall be marked "IIAGP application."

b. Designated staff in the department of human services shall:

(1) Determine eligibility and the amount of payment.

(2) Notify the applicant household of the eligibility decision.

(3) Authorize payment to an eligible household.

(4) Process appeals.

58.6(3) For applications with a voucher request:

a. The local administrative entity for the county shall:

(1) Determine eligibility and the amount of payment.

(2) Notify the applicant household of the eligibility decision.

(3) Authorize vouchers to an eligible household to purchase needed goods and services.

(4) Pay vendors for goods and services purchased with vouchers.

(5) Submit a claim to the department of human services for reimbursement for voucher purchases.

b. Designated staff in the department of human services shall:

(1) Process reimbursement to the local administrative entity for claims.

(2) Process appeals.

[**ARC 9128B**, IAB 10/6/10, effective 10/1/10; **ARC 9312B**, IAB 12/29/10, effective 3/1/11]

441—58.7(29C) Contested cases.

58.7(1) *Reconsideration.* The household may request reconsideration of the department's decisions regarding eligibility and the amount of assistance awarded.

a. To request reconsideration, the household shall submit a written request to the DHS Office of the Deputy Director for Administration, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 15 days of the date of the department's letter notifying the household of its decision.

b. The department shall review any additional evidence or documentation submitted and issue a reconsideration decision within 15 days of receipt of the request.

58.7(2) *Appeal.* The household may appeal the department's reconsideration decision according to procedures in 441—Chapter 7.

a. Appeals must be submitted in writing, either on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, or in any form that provides comparable information, to the DHS Appeals Section, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 15 days of the date of the reconsideration decision.

b. A written appeal is filed on the date the envelope sent to the department is postmarked or, when the postmarked envelope is not available, on the date the appeal is stamped received by the agency.

[**ARC 9312B**, IAB 12/29/10, effective 3/1/11]

441—58.8(29C) Discontinuance of program.

58.8(1) *Deferral to federal assistance.* Upon declaration of a disaster by the President of the United States under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. Sections 5121 to 5206, the Iowa individual assistance grant program administered under this chapter shall be discontinued in the geographic area included in the presidential declaration. Upon issuance of the presidential declaration:

a. No more applications shall be accepted.

b. Any applications that are in process but are not yet approved shall be denied.

c. Persons seeking assistance under this program shall be advised to apply for federal disaster assistance.

58.8(2) *Exhaustion of funds.* The program shall be discontinued when funds available for the program have been exhausted. To ensure equitable treatment, applications for assistance shall be approved on a first-come, first-served basis until all funds have been depleted. "First-come, first-served" is determined by the date the application is approved for payment.

a. Partial payment. Because funds are limited, applications may be approved for less than the amount requested. Payment cannot be approved beyond the amount of funds available.

b. Reserved funds. A portion of allocated funds shall be reserved for final appeal decisions reversing the department's denial that are received after funds for the program have been awarded.

c. Untimely applications. Applications received after the program is discontinued shall be denied.

These rules are intended to implement 2009 Iowa Code Supplement chapter 29C as amended by 2010 Iowa Acts, House File 2294.

441—58.9 to **58.20** Reserved.

DIVISION II
FAMILY INVESTMENT PROGRAM—EMERGENCY ASSISTANCE
[Prior to 10/13/93, 441—58.1 to 58.11]
Rescinded IAB 4/7/10, effective 5/12/10

441—58.21 to **58.40** Reserved.

DIVISION III
TEMPORARY MEASURES RELATED TO DISASTERS

441—58.41(217) Purpose. The rules in this division are intended to allow the department to deliver services more effectively during or following a disaster emergency declared by state or federal officials.

These rules temporarily supersede departmental rules that would otherwise apply, with the primary purpose of reducing barriers to accessing and receiving services that may result from the emergency. The rules shall be tailored to meet special circumstances that arise from a specific disaster emergency and shall be time-limited.

This rule is intended to implement Iowa Code section 217.6.

[**ARC 7577B**, IAB 2/25/09, effective 4/1/09]

441—58.42(234,237A,239B,249,249A,249J,514I) Extension of scheduled reporting and review requirements. Normal scheduled reporting, review, recertification, redetermination, or similar requirements related to continued eligibility are amended as follows:

58.42(1) *Scheduled actions due in June 2008.* For the month of June 2008, no quarterly report, six-month or 12-month review, or similar recertification or redetermination normally required under the following chapters shall be required of households residing in the most affected counties during the month. For all programs except food assistance, the designated counties are Black Hawk, Bremer, Butler, Johnson, and Linn.

1. 441—Chapter 40 (family investment program);
2. 441—Chapter 50 (state supplementary assistance);
3. 441—Chapter 65 (food assistance);
4. 441—Chapter 75, 76, or 83 (medical assistance and family planning waiver);
5. 441—Chapter 86 (HAWK-I);
6. 441—Chapter 92 (IowaCare); or
7. 441—Chapter 170 (child care assistance).

58.42(2) *Scheduled actions due in July and August 2008.* For the months of July and August 2008, no quarterly report, six-month or 12-month review, or similar recertification or redetermination normally required under the following chapters shall be required of households residing in any county of the state:

1. 441—Chapter 40 (family investment program);
2. 441—Chapter 50 (state supplementary assistance);
3. 441—Chapter 65 (food assistance);
4. 441—Chapter 75, 76, or 83 (medical assistance and family planning waiver);
5. 441—Chapter 86 (HAWK-I);
6. 441—Chapter 92 (IowaCare); or
7. 441—Chapter 170 (child care assistance).

58.42(3) *Next scheduled action due.* For those households affected under subrules 58.42(1) and 58.42(2), the next report, review, recertification, or redetermination shall be scheduled as if the action due in June, July, or August 2008 had occurred. For example, if a six-month review was to have occurred in June 2008, the next review will be due in December 2008. Likewise, if a 12-month recertification was due in July 2008, the next recertification will be due in July 2009.

58.42(4) *Continuing to report and act on changes.* Other than as provided by this rule, households shall continue to comply with program requirements for reporting changes in circumstances. Good cause provisions for not reporting changes timely shall apply as provided by existing rules. The department shall continue to act on all changes reported or otherwise known to the department that may affect eligibility or benefits during the extended reporting, review, recertification and redetermination periods provided under this rule.

This rule is intended to implement Iowa Code chapters 234, 237A, 239B, 249, 249A, 249J, and 514I.

[**ARC 7577B**, IAB 2/25/09, effective 4/1/09]

441—58.43(237A) Need for child care services. State child care assistance eligibility requirements concerning need for service in rule 441—170.2(237A,239B) shall be held in abeyance for households residing in governor-declared disaster counties during the months of June, July, and August 2008. Households in those counties that previously met the requirement shall be considered to continue to meet the requirement for those three months if the disaster and ensuing recovery temporarily prevent the household from otherwise meeting this requirement.

This rule is intended to implement Iowa Code section 237A.13.
[**ARC 7577B**, IAB 2/25/09, effective 4/1/09]

441—58.44(249A,249J,514I) Premium payments. Individuals residing in any Iowa county declared by the governor to be a disaster area who would otherwise have their assistance under 441—Chapter 75 (medical assistance), 441—Chapter 86 (HAWK-I), or 441—Chapter 92 (IowaCare) canceled for failure to make a premium payment in the months of June or July 2008 shall not have their assistance canceled for this reason.

This rule is intended to implement Iowa Code chapters 249A, 249J, and 514I.
[**ARC 7577B**, IAB 2/25/09, effective 4/1/09]

441—58.45(249A) Citizenship and identity. Citizenship and identity requirements under 441—Chapter 75 for medical assistance applicants shall be held in abeyance for the months of June, July, and August 2008, for individuals residing in counties declared disaster areas by the governor as provided in this rule.

58.45(1) An affidavit may be used to establish both citizenship and identity when other forms of verification are not available and the department is unable to obtain verification through a match with vital records maintained by the department of public health.

58.45(2) An individual approved for medical assistance under this rule shall be granted a certification period of only three months. At the end of the three-month period, the individual shall be required to provide documentation of citizenship and identity as otherwise required under 441—Chapter 75 to continue eligibility.

This rule is intended to implement Iowa Code chapter 249A.
[**ARC 7577B**, IAB 2/25/09, effective 4/1/09]

441—58.46 to **58.50** Reserved.

DIVISION IV
IOWANS HELPING IOWANS UNMET NEEDS DISASTER ASSISTANCE PROGRAM

PREAMBLE

This division implements a program of state assistance to address unmet disaster-related expenses that cannot be met by other financial assistance. The program provides assistance for repair or replacement of personal property, home repair, food assistance, child care, and temporary housing to households whose income is less than 300 percent of the federal poverty level. The amount of assistance available to a household is capped at $2,500.

The program is administered by the department of human services in coordination with the rebuild Iowa office and local administrative entities designated by the county boards of supervisors.
[**ARC 9130B**, IAB 10/6/10, effective 9/15/10; **ARC 9313B**, IAB 12/29/10, effective 2/2/11]

441—58.51(234) Definitions.

"Department" means the Iowa department of human services.

"Household" means all adults and children who lived in the pre-disaster residence who request individual assistance (not including landlords or other businesses), as well as any persons, such as infants, spouses, or part-time residents, who were not present at the time of the disaster but who are expected to return during the assistance period.

"Local administrative entity" means a county-appointed fiscal entity that performs direct work with households seeking assistance for unmet needs. The local administrative entity certifies the assistance that each household may receive and issues direct reimbursement or purchase vouchers for certified goods or services.

"Unmet need" means an item or service needed to overcome a disaster-related hardship, injury, or adverse condition due to an eligible federally declared disaster resulting in costs or damages related to

personal property, home repair, food assistance, child care, or temporary housing for which the household has not received adequate assistance from any federal, state, nonprofit, or faith-based agency.
[**ARC 9130B**, IAB 10/6/10, effective 9/15/10; **ARC 9313B**, IAB 12/29/10, effective 2/2/11]

441—58.52(234) Program implementation. The Iowans helping Iowans unmet needs disaster assistance program shall be in effect September 15, 2010. This program is available for households affected by natural disasters in those areas identified by the President's Major Disaster Declaration for Individual Assistance, FEMA-1930-DR.

58.52(1) *Funding.* Funding for the program is established by the governor of Iowa through the Iowans helping Iowans program. The rebuild Iowa office will establish a methodology to distribute the funding among the counties in presidentially declared disaster areas.

58.52(2) *Local administration.* To implement the program, the county board of supervisors shall appoint a local administrative entity to administer the program for that county.

a. The local administrative entity may be, but is not limited to:

(1) A local community organization active in disaster (COAD),

(2) A local long-term recovery committee (LTRC),

(3) A nonprofit organization,

(4) A faith-based organization, or

(5) A regional or statewide LTRC.

b. The appointed local administrative entity shall enter into a contract with the department on Form FA 08-30-2010, Fiscal Agent Contract. The contract shall specify the terms for the administration of unmet needs benefits.
[**ARC 9130B**, IAB 10/6/10, effective 9/15/10; **ARC 9313B**, IAB 12/29/10, effective 2/2/11]

441—58.53(234) Application for assistance. To request financial assistance for unmet disaster needs expenses, the household shall complete Form 470-4689, Iowans Helping Iowans Unmet Needs Disaster Assistance Program, and submit the form to the local administrative entity.

58.53(1) Application forms are available from the local administrative entity. Individuals can find their local administrative entity by calling the rebuild Iowa office toll-free at (866)849-0323.

58.53(2) The application shall include:

a. A declaration of the household's annual gross income.

b. A release of confidential information to personnel involved in administering the program.

c. An assurance that the household had no insurance coverage for claimed items or services.

d. A commitment to refund any part of a grant awarded that is duplicated by insurance or by any other assistance program, such as but not limited to other state assistance, local community development groups, charities or faith-based agencies, the Small Business Administration, or the Federal Emergency Management Administration.

e. A copy of a photo identification document for each adult applicant.

f. When vehicle damage is claimed, current copies of the vehicle registration and liability insurance card.
[**ARC 9130B**, IAB 10/6/10, effective 9/15/10; **ARC 9313B**, IAB 12/29/10, effective 2/2/11]

441—58.54(234) Eligibility criteria. To be eligible for assistance, an applicant household must meet all of the following conditions:

58.54(1) The household's residence was located in the disaster area identified by a presidential declaration as described in rule 441—58.52(234), and the household verifies occupancy at that residence.

58.54(2) Household members are citizens of the United States or are legally residing in the United States.

58.54(3) The household's self-declared annual income is at or less than 300 percent of the federal poverty level for a household of that size.

a. Poverty level guidelines are updated annually.

b. All income available to the household is counted, including wages, child support, interest from investments or bank accounts, social security benefits, and retirement income.

58.54(4) The household has disaster-related expenses not covered by insurance, or the claim is less than or equal to the deductible amount. This program shall not reimburse the amount of the insurance deductible when the claim exceeds the deductible amount.

58.54(5) The household has not previously received assistance from this program or another program, such as but not limited to other state assistance, local community development groups, charities or faith-based agencies, the Small Business Administration, or the Federal Emergency Management Administration, for the same loss. The applicant has applied with the Small Business Administration and the Federal Emergency Management Administration but did not receive an award for the items or services included in the unmet needs application.

[**ARC 9130B**, IAB 10/6/10, effective 9/15/10; **ARC 9313B**, IAB 12/29/10, effective 2/2/11]

441—58.55(234) Eligible categories of assistance. The maximum assistance available to a household for a single disaster is $2,500. Assistance is available under the program for the following disaster-related expenses:

1. Personal property.
2. Home repair.
3. Food assistance.
4. Child care.
5. Temporary housing.

[**ARC 9130B**, IAB 10/6/10, effective 9/15/10; **ARC 9313B**, IAB 12/29/10, effective 2/2/11]

441—58.56(234) Eligibility determination and payment.

58.56(1) *Duties of local administrative entity.* The local administrative entity shall perform the following duties:

a. Accept the household's application.

b. Certify that:

(1) The address provided on the application is a valid address in the disaster-affected area,

(2) Disaster-related expenses were a result of the covered disaster,

(3) The household has presented reasonable documentation or receipts for expenses incurred or has reasonable estimates for eligible costs for issuance of a voucher to secure specific eligible goods or services, and

(4) Funds remain available.

c. Determine the amount of assistance the household is eligible to receive by category of assistance and provide the rationale for that amount.

d. Provide the signature of local administrative entity staff making the certification and the date of certification.

e. Notify the applicant household of the certification decision and issue to an approved household:

(1) Reimbursement for documented expenses, or

(2) A voucher to secure specific eligible goods or services.

f. Retain a copy of the household's Form 470-4689, Iowans Helping Iowans Unmet Needs Disaster Assistance Program, and all documentation.

g. Report weekly to the rebuild Iowa office regarding expenditures. Weekly reports shall be in the format prescribed in the agreement.

h. Complete a final reconciliation to substantiate expenditures.

i. Return any unexpended funds to the department within 30 days of the final expenditure or June 30, 2011.

58.56(2) *Local administrative expenses.* A local administrative entity may allocate no more than 5 percent of the amount of assistance provided to households as an administrative expense. Administrative expenses shall be detailed on the weekly report of expenditures.

58.56(3) *Duties of disaster case management office.* Designated staff in the rebuild Iowa disaster case management office shall:

a. Ensure that a local administrative entity is designated in each county affected.

b. Coordinate contact between applicants and their local administrative entity.

c. Support the reconsideration process.

58.56(4) *Duties of the department.* Designated department staff shall:

a. Process grant payments to the local administrative entity or its designee.

b. Process appeals.

[**ARC 9130B**, IAB 10/6/10, effective 9/15/10; **ARC 9313B**, IAB 12/29/10, effective 2/2/11]

441—58.57(234) Contested cases.

58.57(1) *Reconsideration.* The household may request reconsideration of the local administrative entity's decision regarding certification of eligible unmet needs and the amount of reimbursement awarded.

a. To request reconsideration, the household shall submit a written request to the Rebuild Iowa Office, Wallace State Office Building, 502 East Ninth Street, Des Moines, Iowa 50319, within 15 days of the date of the local administrative entity's notification to the household of its decision.

b. The rebuild Iowa disaster recovery case management office shall:

(1) Review any additional evidence or documentation submitted,

(2) Issue a reconsideration decision within 15 days of receipt of the request, and

(3) Notify the household of the reconsideration decision.

58.57(2) *Appeal.* The household may appeal the rebuild Iowa office reconsideration decision according to procedures in 441—Chapter 7.

a. Appeals must be submitted:

(1) In writing, either on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, or in any form that provides comparable information;

(2) To the DHS Appeals Section, 1305 East Walnut Street, Des Moines, Iowa 50319-0114;

(3) Within 15 days of the date of the reconsideration decision.

b. A written appeal is filed on the date the envelope sent to the department is postmarked or, when the postmarked envelope is not available, on the date the appeal is stamped received by the department.

[**ARC 9130B**, IAB 10/6/10, effective 9/15/10; **ARC 9313B**, IAB 12/29/10, effective 2/2/11]

441—58.58(234) Discontinuance of program. The Iowans helping Iowans unmet needs disaster assistance program administered under this division shall be discontinued upon exhaustion of allocated funds or on June 30, 2011, whichever occurs first.

[**ARC 9130B**, IAB 10/6/10, effective 9/15/10; **ARC 9313B**, IAB 12/29/10, effective 2/2/11]

These rules are intended to implement Iowa Code section 234.6.

441—58.59 and **58.60** Reserved.

DIVISION V
TICKET TO HOPE PROGRAM

PREAMBLE

This division implements the ticket to hope program, a mental health counseling program funded through a social services emergency disaster relief grant that was authorized by Public Law 110-329, the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act of 2009. The program pays for professional mental health evaluation and treatment services for individuals and families who have been affected by the weather-related disasters of 2008.

[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

441—58.61(234) Definitions.

"Department" means the Iowa department of human services.

"Ticket to hope" means the mental health counseling program for individuals and families who have been directly affected by the weather-related disasters of 2008.

[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

441—58.62(234) Application process. The process for obtaining assistance from the ticket to hope program is as follows:

58.62(1) A person requesting assistance shall contact the Iowa concern hotline by telephone at 1-800-447-1985.

58.62(2) The Iowa concern hotline shall gather information and determine eligibility for ticket to hope services based on criteria established in this division.

58.62(3) The Iowa concern hotline shall send to each eligible applicant a packet of information that includes:

a. An introductory cover letter;

b. A list of participating providers;

c. An authorization form for one 45- to 50-minute session (valid for 30 days); and

d. A demographic data form that includes a unique numeric client identifier.

58.62(4) The eligible applicant shall:

a. Make an appointment with an approved provider; and

b. Give the authorization and demographic data forms to the provider at the time of the appointment.

58.62(5) After the eligible applicant meets with the provider, the applicant may call the Iowa concern hotline and receive authorization for up to seven additional sessions. A new authorization form shall be issued for each session.

[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

441—58.63(234) Eligibility criteria. To be eligible for assistance, a person living in Iowa must report:

1. That the impact of the 2008 disaster has impaired the person's ability to carry out normal daily functions to some extent; and

2. That the person has no insurance coverage for mental health services, or has insurance with a high deductible that will deter the person from accessing necessary mental health services.

[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

441—58.64(234) Provider participation. A mental health professional with an active professional license issued by the Iowa department of public health who is qualified to provide individual psychotherapy (i.e., Current Procedural Terminology code 90806, "individual psychotherapy, insight-oriented behavior modification or support, provided face to face with the patient in an office or outpatient setting") according to the Iowa Plan vendor requirements shall be allowed to participate as a ticket to hope provider.

58.64(1) A mental health professional applying to participate in the program shall submit a copy of the professional license to the Iowa concern hotline.

58.64(2) The mental health professional shall agree to the terms of participation in the ticket to hope program by:

a. Signing a professional services agreement with the department; and

b. Returning the signed agreement to the Iowa concern hotline.

[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

441—58.65(234) Provider reimbursement. A provider approved to participate shall be reimbursed as follows:

58.65(1) The provider shall submit a completed demographic data form and the authorization form to the Iowa concern hotline within 30 days after each completed session with an approved applicant.

58.65(2) The provider shall be reimbursed at the lower of:

a. A rate of $93 per assessment or counseling session, or

b. The prevailing Iowa Medicaid rate.

[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

441—58.66(234) Reconsideration. An applicant may request reconsideration of a denial of access to services. A mental health professional may request reconsideration of a denial to be a part of the professional provider panel.

58.66(1) To request reconsideration, the person shall submit a written request to the DHS Division of Mental Health and Disability Services, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

58.66(2) The department shall review any additional evidence or documentation submitted and issue a reconsideration decision within 15 days from receipt of the request.

[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

441—58.67(234) Appeal. The person may appeal the department's reconsideration decision according to procedures in 441—Chapter 7.

58.67(1) Appeals must be submitted in writing, either on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, or in any form that provides comparable information, to the DHS Appeals Section, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 15 days of the date of the reconsideration decision.

58.67(2) A written appeal is filed on the date the envelope sent to the department is postmarked or, when the postmarked envelope is not available, on the date the appeal is stamped received by the department.

[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

441—58.68(234) Discontinuance of program. The program shall end on June 30, 2010, or when the funds are expended, whichever occurs first.

[**ARC 7641B**, IAB 3/25/09, effective 3/1/09; **ARC 7830B**, IAB 6/3/09, effective 7/8/09]

These rules are intended to implement Iowa Code section 234.6.

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CHAPTER 77
CONDITIONS OF PARTICIPATION FOR PROVIDERS OF MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 77]
[Prior to 2/11/87, Human Services[498]]

441—77.1(249A) Physicians. All physicians (doctors of medicine and osteopathy) licensed to practice in the state of Iowa are eligible to participate in the program. Physicians in other states are also eligible if duly licensed to practice in that state.

441—77.2(249A) Retail pharmacies. Pharmacies are eligible to participate providing they are licensed in the state of Iowa or duly licensed in other states.

441—77.3(249A) Hospitals. All hospitals licensed in the state of Iowa and certified as eligible to participate in Part A of the Medicare program (Title XVIII of the Social Security Act) are eligible to participate in the medical assistance program. Hospitals in other states are also eligible if duly licensed and certified for Medicare participation in that state.

441—77.4(249A) Dentists. All dentists licensed to practice in the state of Iowa are eligible to participate in the program. Dentists in other states are also eligible if duly licensed to practice in that state.

NOTE: DENTAL LABORATORIES—Payment will not be made to a dental laboratory.

441—77.5(249A) Podiatrists. All podiatrists licensed to practice in the state of Iowa are eligible to participate in the program. Podiatrists in other states are also eligible if duly licensed to practice in that state.

441—77.6(249A) Optometrists. All optometrists licensed to practice in the state of Iowa are eligible to participate in the program. Optometrists in other states are also eligible if duly licensed to practice in that state.

441—77.7(249A) Opticians. All opticians in the state of Iowa are eligible to participate in the program. Opticians in other states are also eligible to participate.

NOTE: Opticians in states having licensing requirements for this professional group must be duly licensed in that state.

441—77.8(249A) Chiropractors. All chiropractors licensed to practice in the state of Iowa are eligible to participate providing they have been determined eligible to participate in Title XVIII of the Social Security Act (Medicare) by the Social Security Administration. Chiropractors in other states are also eligible if duly licensed to practice in that state and determined eligible to participate in Title XVIII of the Social Security Act.

441—77.9(249A) Home health agencies. Home health agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act) and, unless exempted under subrule 77.9(5), have submitted a surety bond as required by subrules 77.9(1) to 77.9(6).

77.9(1) *Definitions.*

"Assets" includes any listing that identifies Medicaid members to whom home health services were furnished by a participating or formerly participating home health agency.

"Rider" means a notice issued by a surety that a change in the bond has occurred or will occur.

"Uncollected overpayment" means a Medicaid overpayment, including accrued interest, for which the home health agency is responsible that has not been recouped by the department within 60 days from the date of notification that an overpayment has been identified.

77.9(2) *Parties to surety bonds.* The surety bond shall name the home health agency as the principal, the Iowa department of human services as the obligee and the surety company (and its heirs, executors, administrators, successors and assignees, jointly and severally) as surety. The bond shall be issued by

a company holding a current Certificate of Authority issued by the U.S. Department of the Treasury in accordance with 31 U.S.C. Sections 9304 to 9308 and 31 CFR Part 223 as amended to November 30, 1984, Part 224 as amended to May 29, 1996, and Part 225 as amended to September 12, 1974. The bond shall list the surety's name, street address or post office box number, city, state and ZIP code. The company shall not have been determined by the department to be unauthorized in Iowa due to:

a. Failure to furnish timely confirmation of the issuance of and the validity and accuracy of information appearing on a surety bond that a home health agency presents to the department that shows the surety company as surety on the bond.

b. Failure to timely pay the department in full the amount requested, up to the face amount of the bond, upon presentation by the department to the surety company of a request for payment on a surety bond and of sufficient evidence to establish the surety company's liability on the bond.

c. Other good cause.

The department shall give public notice of a determination that a surety company is unauthorized in Iowa and the effective date of the determination by publication of a notice in the newspaper of widest circulation in each city in Iowa with a population of 50,000 or more. A list of surety companies determined by the department to be unauthorized in Iowa shall be maintained and shall be available for public inspection by contacting the division of medical services of the department. The determination that a surety company is unauthorized in Iowa has effect only in Iowa and is not a debarment, suspension, or exclusion for the purposes of Federal Executive Order No. 12549.

77.9(3) *Surety company obligations.* The bond shall guarantee payment to the department, up to the face amount of the bond, of the full amount of any uncollected overpayment, including accrued interest, based on payments made to the home health agency during the term of the bond. The bond shall provide that payment may be demanded from the surety after available administrative collection methods for collecting from the home health agency have been exhausted.

77.9(4) *Surety bond requirements.* Surety bonds secured by home health agencies participating in Medicaid shall comply with the following requirements:

a. Effective dates and submission dates.

(1) Home health agencies participating in the program on June 10, 1998, shall secure either an initial surety bond for the period January 1, 1998, through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(2) Home health agencies seeking to participate in Medicaid and Medicare for the first time after June 10, 1998, shall secure an initial surety bond for the period from Medicaid certification through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(3) Medicare-certified home health agencies seeking to participate in Medicaid for the first time after June 10, 1998, shall secure an initial surety bond for the period from Medicaid certification through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(4) Home health agencies seeking to participate in Medicaid after purchasing the assets of or an ownership interest in a participating or formerly participating agency shall secure an initial surety bond effective as of the date of purchase of the assets or the transfer of the ownership interest for the balance of the current fiscal year of the home health agency or a continuous bond which remains in effect from year to year.

(5) Home health agencies which continue to participate in Medicaid after the period covered by an initial surety bond shall secure a surety bond for each subsequent fiscal year of the home health agency or a continuous bond which remains in effect from year to year.

b. Amount of bond. Bonds for any period shall be in the amount of $50,000 or 15 percent of the home health agency's annual Medicaid payments during the most recently completed state fiscal year, whichever is greater. After June 1, 2005, all bonds shall be in the amount of $50,000. At least 90 days before the start of each home health agency's fiscal year, the department shall provide notice of the amount of the surety bond to be purchased and submitted to the Iowa Medicaid enterprise provider services unit.

c. Other requirements. Surety bonds shall meet the following additional requirements. The bond shall:

(1) Guarantee that upon written demand by the department to the surety for payment under the bond and the department's furnishing to the surety sufficient evidence to establish the surety's liability under the bond, the surety shall within 60 days pay the department the amount so demanded, up to the stated amount of the bond.

(2) Provide that the surety's liability for uncollected overpayments is based on overpayments determined during the term of the bond.

(3) Provide that the surety's liability to the department is not extinguished by any of the following:

1. Any action by the home health agency or the surety to terminate or limit the scope or term of the bond unless the surety furnishes the department with notice of the action not later than 10 days after the date of notice of the action by the home health agency to the surety and not later than 60 days before the effective date of the action by the surety.

2. The surety's failure to continue to meet the requirements in subrule 77.9(2) or the department's determination that the surety company is an unauthorized surety under subrule 77.9(2).

3. Termination of the home health agency's provider agreement.

4. Any action by the department to suspend, offset, or otherwise recover payments to the home health agency.

5. Any action by the home health agency to cease operations, sell or transfer any assets or ownership interest, file for bankruptcy, or fail to pay the surety.

6. Any fraud, misrepresentation, or negligence by the home health agency in obtaining the surety bond or by the surety (or the surety's agent, if any) in issuing the surety bond; except that any fraud, misrepresentation, or negligence by the home health agency in identifying to the surety (or the surety's agent) the amount of Medicaid payments upon which the amount of the surety bond is determined shall not cause the surety's liability to the department to exceed the amount of the bond.

7. The home health agency's failure to exercise available appeal rights under Medicaid or assign appeal rights to the surety.

(4) Provide that if a home health agency fails to furnish a bond following the expiration date of an annual bond or if a home health agency fails to furnish a rider for a year in which a rider is required or if the home health agency's provider agreement with the department is terminated, the surety shall remain liable under the most recent annual bond or rider to a continuous bond for two years from the date the home health agency was required to submit the annual bond or rider to a continuous bond or for two years from the termination date of the provider agreement.

(5) Provide that actions under the bond may be brought by the department or by an agent designated by the department.

(6) Provide that the surety may appeal department decisions.

77.9(5) *Exemption from surety bond requirements for government-operated home health agencies.* A home health agency operated by a federal, state, local, or tribal government agency is exempt from the bonding requirements of this rule if, during the preceding five years, the home health agency has not had any uncollected overpayments. Government-operated home health agencies having uncollected overpayments during the preceding five years shall not be exempted from the bonding requirements of this rule.

77.9(6) *Government-operated home health agency that loses its exemption.* A government-operated home health agency which has met the criteria for an exemption under subrule 77.9(6) but is later determined by the department not to meet the criteria shall submit a surety bond within 60 days of the date of the department's written notification to the home health agency that it no longer meets the criteria for an exemption, for the period and in the amount required in the notice from the department.

441—77.10(249A) Medical equipment and appliances, prosthetic devices and medical supplies. All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate in the program.

441—77.11(249A) Ambulance service. Providers of ambulance service are eligible to participate providing they meet the eligibility requirements for participation in the Medicare program (Title XVIII of the Social Security Act).

441—77.12(249A) Remedial services providers. A provider of remedial services is eligible to participate in the medical assistance program when:

1. The provider is accredited by the mental health, mental retardation, developmental disabilities, and brain injury commission pursuant to 441—Chapter 24; or
2. The provider was certified by the department as a provider of rehabilitative treatment services pursuant to 441—185.10(234) before September 1, 2006; or
3. The provider can demonstrate to the Iowa Medicaid enterprise that the provider has the skills and resources necessary to implement a member's treatment plan and remedial services implementation plan.

This rule is intended to implement Iowa Code section 249A.4.
[**ARC 7741B**, IAB 5/6/09, effective 7/1/09]

441—77.13(249A) Hearing aid dispensers. Hearing aid dispensers are eligible to participate if they are duly licensed by the state of Iowa. Hearing aid dispensers in other states will be eligible to participate if they are duly licensed in that state.

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

441—77.14(249A) Audiologists. Audiologists are eligible to participate in the program when they are duly licensed by the state of Iowa. Audiologists in other states will be eligible to participate when they are duly licensed in that state. In states having no licensure requirement for audiologists, an audiologist shall obtain a license from the state of Iowa.

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

441—77.15(249A) Community mental health centers. Community mental health centers are eligible to participate in the medical assistance program when they comply with the standards for mental health centers in the state of Iowa established by the Iowa mental health authority.

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

441—77.16(249A) Screening centers. Public or private health agencies are eligible to participate as screening centers when they have the staff and facilities needed to perform all of the elements of screening specified in 441—78.18(249A) and meet the department of public health's standards for a child health screening center. The staff members must be employed by or under contract with the screening center. Screening centers shall direct applications to participate to the Iowa Medicaid enterprise provider services unit.

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

441—77.17(249A) Physical therapists. Physical therapists are eligible to participate when they are licensed, in independent practice; and are eligible to participate in the Medicare program.

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

441—77.18(249A) Orthopedic shoe dealers and repair shops. Establishments eligible to participate in the medical assistance program are retail dealers in orthopedic shoes prescribed by physicians or podiatrists and shoe repair shops specializing in orthopedic work as prescribed by physicians or podiatrists.

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

441—77.19(249A) Rehabilitation agencies. Rehabilitation agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

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

441—77.20(249A) Independent laboratories. Independent laboratories are eligible to participate providing they are certified to participate as a laboratory in the Medicare program (Title XVIII of the Social Security Act). An independent laboratory is a laboratory that is independent of attending and consulting physicians' offices, hospitals, and critical access hospitals.

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

441—77.21(249A) Rural health clinics. Rural health clinics are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

441—77.22(249A) Psychologists. All psychologists licensed to practice in the state of Iowa and meeting the standards of the National Register of Health Service Providers in Psychology, 1981 edition, published by the council for the National Register of Health Service Providers in Psychology, are eligible to participate in the medical assistance program. Psychologists in other states are eligible to participate when they are duly licensed to practice in that state and meet the standards of the National Register of Health Service Providers in Psychology.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

441—77.23(249A) Maternal health centers. A maternal health center is eligible to participate in the Medicaid program if the center provides a team of professionals to render prenatal and postpartum care and enhanced perinatal services (see rule 441—78.25(249A)). The prenatal and postpartum care shall be in accordance with the latest edition of the American College of Obstetricians and Gynecologists, Standards for Obstetric Gynecologic Services. The team must have at least a physician, a registered nurse, a licensed dietitian and a person with at least a bachelor's degree in social work, counseling, sociology or psychology. Team members must be employed by or under contract with the center.

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

441—77.24(249A) Ambulatory surgical centers. Ambulatory surgical centers that are not part of hospitals are eligible to participate in the medical assistance program if they are certified to participate in the Medicare program (Title XVIII of the Social Security Act). Freestanding ambulatory surgical centers providing only dental services are also eligible to participate in the medical assistance program if the board of dental examiners has issued a current permit pursuant to 650—Chapter 29 for any dentist to administer deep sedation or general anesthesia at the facility.

441—77.25(249A) Home- and community-based habilitation services. To be eligible to participate in the Medicaid program as an approved provider of home- and community-based habilitation services, a provider shall meet the general requirements in subrules 77.25(2), 77.25(3), and 77.25(4) and shall meet the requirements in the subrules applicable to the individual services being provided.

77.25(1) *Definitions.*

"Guardian" means a guardian appointed in probate or juvenile court.

"Major incident" means an occurrence involving a member during service provision that:

1. Results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the member;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;

6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or

7. Involves a member's location being unknown by provider staff who are assigned protective oversight.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Minor incident" means an occurrence involving a member during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

77.25(2) *Organization and staff.*

a. The prospective provider shall demonstrate the fiscal capacity to initiate and operate the specified programs on an ongoing basis.

b. The provider shall complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employing a person who will provide direct care.

c. A person providing direct care shall be at least 16 years of age.

d. A person providing direct care shall not be an immediate family member of the member.

77.25(3) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS habilitation service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule.

a. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the member's file.

b. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The member or the member's legal guardian. EXCEPTION: Notification to the member is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The member's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the member involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other members or nonmembers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the member's file.

c. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of members served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.25(4) *Restraint, restriction, and behavioral intervention.* The provider shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures. All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

a. The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.

b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.

c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.

d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.

e. Corporal punishment and verbal or physical abuse are prohibited.

77.25(5) *Case management.* The department of human services, a county or consortium of counties, or a provider under subcontract to the department or to a county or consortium of counties is eligible to participate in the home- and community-based habilitation services program as a provider of case management services provided that the agency meets the standards in 441—Chapter 24.

77.25(6) *Day habilitation.* The following providers may provide day habilitation:

a. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation under 441—subrule 78.27(8).

b. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide other services and began providing services that qualify as day habilitation under 441—subrule 78.27(8) since the agency's last accreditation survey. The agency may provide day habilitation services until the current accreditation expires. When the current accreditation expires, the agency must qualify under paragraph *"a," "d," "g,"* or *"h."*

c. An agency that is not accredited by the Commission on Accreditation of Rehabilitation Facilities but has applied to the Commission within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.27(8). An agency that has not received accreditation within 12 months after application to the Commission is no longer a qualified provider.

d. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

e. An agency that has applied to the Council on Quality and Leadership in Supports for People with Disabilities for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

f. An agency that is accredited under 441—Chapter 24 to provide day treatment or supported community living services.

g. An agency that is certified by the department to provide day habilitation services under the home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A).

h. An agency that is accredited by the International Center for Clubhouse Development.

i. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

j. A residential care facility of more than 16 beds that is licensed by the Iowa department of inspections and appeals, was enrolled as a provider of rehabilitation services for adults with chronic mental illness before December 31, 2006, and has applied for accreditation through one of the accrediting bodies listed in this subrule.

(1) The facility must have policies in place by June 30, 2007, consistent with the accreditation being sought.

(2) A facility that has not received accreditation within 12 months after application for accreditation is no longer a qualified provider.

77.25(7) *Home-based habilitation.* The following agencies may provide home-based habilitation services:

a. An agency that is certified by the department to provide supported community living services under:

(1) The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

b. An agency that is accredited under 441—Chapter 24 to provide supported community living services.

c. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as a community housing or supported living service provider.

d. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

e. An agency that is accredited by the Council on Accreditation of Services for Families and Children.

f. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

g. A residential care facility of 16 or fewer beds that is licensed by the Iowa department of inspections and appeals, was enrolled as a provider of rehabilitation services for adults with chronic mental illness before December 31, 2006, and has applied for accreditation through one of the accrediting bodies listed in this subrule.

(1) The facility must have policies in place by June 30, 2007, consistent with the accreditation being sought.

(2) A facility that has not received accreditation within 12 months after application for accreditation is no longer a qualified provider.

77.25(8) *Prevocational habilitation.* The following providers may provide prevocational services:

a. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

b. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

c. An agency that is accredited by the International Center for Clubhouse Development.

d. An agency that is certified by the department to provide prevocational services under:

(1) The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

77.25(9) *Supported employment habilitation.* The following agencies may provide supported employment services:

a. An agency that is certified by the department to provide supported employment services under:

(1) The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

b. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

c. An agency that is accredited by the Council on Accreditation of Services for Families and Children.

d. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

e. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

f. An agency that is accredited by the International Center for Clubhouse Development.

77.25(10) *Provider enrollment.* A prospective provider that meets the criteria in this rule shall be enrolled as an approved provider of a specific component of home- and community-based habilitation services. Enrollment carries no assurance that the approved provider will receive funding. Payment for services will be made to a provider only upon department approval of the provider and of the service the provider is authorized to provide.

a. The Iowa Medicaid enterprise shall review compliance with standards for initial enrollment. Review of a provider may occur at any time.

b. The department may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This information may include:

(1) Current accreditations.

(2) Evaluations.

(3) Inspection reports.

(4) Reviews by regulatory and licensing agencies and associations.

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11]

441—77.26(249A) Behavioral health services. The following persons are eligible to participate in the Medicaid program as providers of behavioral health services.

77.26(1) *Licensed marital and family therapists (LMFT).* Any person licensed by the board of behavioral science as a marital and family therapist pursuant to 645—Chapter 31 is eligible to participate. A marital and family therapist in another state is eligible to participate when duly licensed to practice in that state.

77.26(2) *Licensed independent social workers (LISW).* Any person licensed by the board of social work as an independent social worker pursuant to 645—Chapter 280 is eligible to participate. An independent social worker in another state is eligible to participate when duly licensed to practice in that state.

77.26(3) *Licensed master social workers (LMSW).*

a. A person licensed by the board of social work as a master social worker pursuant to 645—Chapter 280 is eligible to participate when the person:

(1) Holds a master's or doctoral degree as approved by the board of social work; and

(2) Provides treatment under the supervision of an independent social worker licensed pursuant to 645—Chapter 280.

b. A master social worker in another state is eligible to participate when the person:

(1) Is duly licensed to practice in that state; and

(2) Provides treatment under the supervision of an independent social worker duly licensed in that state.

This rule is intended to implement Iowa Code chapter 249A as amended by 2008 Iowa Acts, Senate File 2425, section 123.

441—77.27(249A) Birth centers. Birth centers are eligible to participate in the Medicaid program if they are licensed or receive reimbursement from at least two third-party payors.

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

441—77.28(249A) Area education agencies. An area education agency is eligible to participate in the Medicaid program when it has a plan for providing comprehensive special education programs and services approved by the Iowa department of education. Covered services shall be provided by personnel who are licensed, endorsed, or registered as provided in this rule and shall be within the scope of the applicable license, endorsement, or registration.

77.28(1) Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

77.28(2) Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

77.28(3) Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

77.28(4) Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

a. Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

b. Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

c. Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

d. Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

e. Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

77.28(5) Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

77.28(6) Personnel providing vision services shall be:

a. Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;

b. Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

c. Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

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

441—77.29(249A) Case management provider organizations. Case management provider organizations are eligible to participate in the Medicaid program provided that they meet the standards for the populations being served. Providers shall meet the following standards:

77.29(1) *Standards in 441—Chapter 24.* Providers shall meet the standards in 441—Chapter 24 when they are the department of human services, a county or consortium of counties, or an agency or provider under subcontract to the department or a county or consortium of counties providing case management services to persons with mental retardation, developmental disabilities or chronic mental illness.

77.29(2) *Standards in 441—Chapter 186.* Rescinded IAB 10/12/05, effective 10/1/05.

441—77.30(249A) HCBS ill and handicapped waiver service providers. HCBS ill and handicapped waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled

HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A provider hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS ill and handicapped waiver program if they meet the standards in subrule 77.30(18) and also meet the standards set forth below for the service to be provided:

77.30(1) *Homemaker providers.* Homemaker providers shall be agencies that are:

a. Certified as a home health agency under Medicare, or

b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

77.30(2) *Home health aide providers.* Home health aide providers shall be agencies which are certified to participate in the Medicare program.

77.30(3) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.30(4) *Nursing care providers.* Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

77.30(5) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Respite providers certified under the home- and community-based services intellectual disability or brain injury waiver.

(3) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(5) Camps certified by the American Camping Association.

(6) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).

(7) Adult day care providers that meet the conditions of participation set forth in subrule 77.30(3).

(8) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

(9) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(10) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.30(6) *Counseling providers.* Counseling providers shall be:

a. Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

b. Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

c. Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

77.30(7) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.30(8) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Child care facilities, which are defined as child care centers licensed pursuant to 441—Chapter 109, preschools, or child development homes registered pursuant to 441—Chapter 110.

(2) Rescinded IAB 9/1/04, effective 11/1/04.

(3) Rescinded IAB 9/1/04, effective 11/1/04.

(4) Home health agencies certified to participate in the Medicare program.

(5) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.

(3) Not be a usual caregiver of the member.

(4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.30(9) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Area agencies on aging as designated in 17—4.4(231).

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Providers eligible to participate as home and vehicle modification providers under the elderly waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.

d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

77.30(10) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies that meet the conditions of participation set forth in subrule 77.33(2).

77.30(11) *Home-delivered meals.* The following providers may provide home-delivered meals:

a. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Restaurants licensed and inspected under Iowa Code chapter 137F.

e. Hospitals enrolled as Medicaid providers.

f. Home health aide providers meeting the standards set forth in subrule 77.33(3).

g. Medical equipment and supply dealers certified to participate in the Medicaid program.

h. Home care providers meeting the standards set forth in subrule 77.33(4).

77.30(12) *Nutritional counseling.* The following providers may provide nutritional counseling by a dietitian licensed under 645—Chapter 81:

a. Hospitals enrolled as Medicaid providers.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Home health agencies certified by Medicare.

e. Independent licensed dietitians approved by an area agency on aging.

77.30(13) *Financial management service.* Members who elect the consumer choices option shall work with a financial institution that meets the following qualifications.

a. The financial institution shall either:

(1) Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the credit union division of the Iowa department of commerce; or

(2) Be chartered by the Office of the Comptroller of the Currency, a bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC).

b. The financial institution shall complete a financial management readiness review and certification conducted by the department or its designee.

c. The financial institution shall obtain an Internal Revenue Service federal employee identification number dedicated to the financial management service.

d. The financial institution shall enroll as a Medicaid provider.

77.30(14) *Independent support brokerage.* Members who elect the consumer choices option shall work with an independent support broker who meets the following qualifications.

a. The broker must be at least 18 years of age.

b. The broker shall not be the member's guardian, conservator, attorney in fact under a durable power of attorney for health care, power of attorney for financial matters, trustee, or representative payee.

c. The broker shall not provide any other paid service to the member.

d. The broker shall not work for an individual or entity that is providing services to the member.

e. The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the member.

f. The broker must complete independent support brokerage training approved by the department.

77.30(15) *Self-directed personal care.* Members who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the following requirements.

a. A business providing self-directed personal care services shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

b. An individual providing self-directed personal care services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

c. All personnel providing self-directed personal care services shall:

(1) Be at least 16 years of age.

(2) Be able to communicate successfully with the member.

(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

(5) Not be the parent or stepparent of a minor child member or the spouse of a member.

d. The provider of self-directed personal care services shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

77.30(16) *Individual-directed goods and services.* Members who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the following requirements.

a. A business providing individual-directed goods and services shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

b. An individual providing individual-directed goods and services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

c. All personnel providing individual-directed goods and services shall:

(1) Be at least 18 years of age.

(2) Be able to communicate successfully with the member.

(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

(5) Not be the parent or stepparent of a minor child member or the spouse of a member.

d. The provider of individual-directed goods and services shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

77.30(17) *Self-directed community supports and employment.* Members who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the following requirements.

a. A business providing community supports and employment shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

b. An individual providing self-directed community supports and employment shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

c. All personnel providing self-directed community supports and employment shall:

(1) Be at least 18 years of age.

(2) Be able to communicate successfully with the member.

(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

(5) Not be the parent or stepparent of a minor child member or the spouse of a member.

d. The provider of self-directed community supports and employment shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

77.30(18) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS ill and handicapped waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, home-delivered meals, or personal emergency response.

a. Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11]

441—77.31(249A) Occupational therapists. Occupational therapists are eligible to participate if they are licensed and in private practice independent of the administrative and professional control of an employer such as a physician, institution, or rehabilitation agency. Licensed occupational therapists in an independent group practice are eligible to enroll.

77.31(1) Occupational therapists in other states are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

77.31(2) Occupational therapists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

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

441—77.32(249A) Hospice providers. Hospice providers are eligible to participate in the Medicaid program providing they are certified to participate in the Medicare program.

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

441—77.33(249A) HCBS elderly waiver service providers. HCBS elderly waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS elderly waiver program if they meet the standards in subrule 77.33(22) and also meet the standards set forth below for the service to be provided:

77.33(1) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.33(2) *Emergency response system providers.* Emergency response system providers must meet the following standards:

a. The agency shall provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station must operate receiving equipment and be fully staffed by trained attendants, 24 hours a day, seven days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.

b. The agency, parent agency, institution or corporation shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

c. There shall be a governing authority which is responsible for establishing policy and ensuring effective control of services and finances. The governing authority shall employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.

d. The agency or institution shall be in compliance with all legislation relating to prohibition of discriminatory practices.

e. There shall be written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.

77.33(3) *Home health aide providers.* Home health aide providers shall be agencies certified to participate in the Medicare program as home health agencies.

77.33(4) *Homemaker providers.* Homemaker providers shall be agencies that are:

a. Certified as a home health agency under Medicare, or

b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

77.33(5) *Nursing care.* Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

77.33(6) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Nursing facilities and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Camps certified by the American Camping Association.

(4) Respite providers certified under the home- and community-based services intellectual disability waiver.

(5) Home care agencies that meet the conditions of participation set forth in subrule 77.33(4).

(6) Adult day care providers that meet the conditions set forth in subrule 77.33(1).

(7) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the spouse, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.33(7) *Chore providers.* The following providers may provide chore services:

a. Home health agencies certified under Medicare.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

e. Providers that were enrolled as chore providers as of June 30, 2010, based on a subcontract with or letter of approval from an area agency on aging.

f. Community businesses that are engaged in the provision of chore services and that:

(1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and

(2) Submit verification of current liability and workers' compensation coverage.

77.33(8) *Home-delivered meals.* The following providers may provide home-delivered meals:

a. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Restaurants licensed and inspected under Iowa Code chapter 137F.

e. Hospitals enrolled as Medicaid providers.

f. Home health aide providers meeting the standards set forth in subrule 77.33(3).

g. Medical equipment and supply dealers certified to participate in the Medicaid program.

h. Home care providers meeting the standards set forth in subrule 77.33(4).

77.33(9) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Area agencies on aging as designated in 17—4.4(231).

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Providers eligible to participate as home and vehicle modification provides under the ill and handicapped waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.

d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

77.33(10) *Mental health outreach providers.* Community mental health centers or other mental health providers accredited by the mental health and developmental disabilities commission pursuant to 441—Chapter 24 may provide mental health outreach services.

77.33(11) *Transportation providers.* The following providers may provide transportation:

a. Area agencies on aging as designated in 17—4.4(231). Transportation providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services may also provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Rescinded IAB 3/10/99, effective 5/1/99.

e. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

77.33(12) *Nutritional counseling.* The following providers may provide nutritional counseling by a dietitian licensed under 645—Chapter 81:

a. Hospitals enrolled as Medicaid providers.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Home health agencies certified by Medicare.

e. Independent licensed dietitians.

77.33(13) *Assistive device providers.* The following providers may provide assistive devices:

a. Medicaid-enrolled medical equipment and supply dealers.

b. Area agencies on aging as designated according to department on aging rules 17—4.4(231) and 17—4.9(231).

c. Providers that were enrolled as assistive device providers as of June 30, 2010, based on a contract with or letter of approval from an area agency on aging.

d. Community businesses that are engaged in the provision of assistive devices and that:

(1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and

(2) Submit verification of current liability and workers' compensation coverage.

77.33(14) *Senior companions.* Senior companion programs designated by the Corporation for National and Community Service may provide senior companion service.

77.33(15) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.33(16) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.33(17) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.33(18) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.33(19) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.33(20) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

77.33(21) *Case management providers.* A case management provider organization is eligible to participate in the Medicaid HCBS elderly waiver program if the organization meets the following standards:

a. The case management provider shall be an agency or individual that:

(1) Is accredited by the mental health, mental retardation, developmental disabilities, and brain injury commission as meeting the standards for case management services in 441—Chapter 24; or

(2) Is accredited through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to provide case management; or

(3) Is accredited through the Council on Accreditation of Rehabilitation Facilities (CARF) to provide case management; or

(4) Is accredited through the Council on Quality and Leadership in Supports for People with Disabilities (CQL) to provide case management; or

(5) Is approved by the department on aging as meeting the standards for case management services in 17—Chapter 21; or

(6) Is authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services and that:

1. Meets the qualifications for case managers in 641—subrule 80.6(1); and

2. Provides a current IDPH local public health services contract number.

b. A case management provider shall not provide direct services to the consumer. The department and the Centers for Medicare and Medicaid Services deem the provision of direct services to case management consumers to be a conflict of interest. A person cannot be the first-line supervisor of both case managers and direct service staff who are providing services to elderly waiver consumers. The provider must have written conflict of interest policies that include, but are not limited to:

(1) Specific procedures to identify conflicts of interest.

(2) Procedures to eliminate any conflict of interest that is identified.

(3) Procedures for handling complaints of conflict of interest, including written documentation.

c. If the case management provider organization subcontracts case management services to another entity:

(1) That entity must also meet the provider qualifications in this subrule; and

(2) The contractor is responsible for verification of compliance.

77.33(22) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS elderly waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of assistive devices, chore service, goods and services purchased under the consumer choices option, home and vehicle modification, home-delivered meals, personal emergency response, or transportation.

a. Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;

2. Results in the death of any person;

3. Requires emergency mental health treatment for the consumer;

4. Requires the intervention of law enforcement;

5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;

6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or

7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11]

441—77.34(249A) HCBS AIDS/HIV waiver service providers. HCBS AIDS/HIV waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS AIDS/HIV waiver program if they meet the standards in subrule 77.34(14) and also meet the standards set forth below for the service to be provided:

77.34(1) *Counseling providers.* Counseling providers shall be:

a. Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

b. Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

c. Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

77.34(2) *Home health aide providers.* Home health aide providers shall be agencies which are certified to participate in the Medicare program.

77.34(3) *Homemaker providers.* Homemaker providers shall be agencies that are:

a. Certified as a home health agency under Medicare, or

b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

77.34(4) *Nursing care providers.* Nursing care providers shall be agencies which are certified to meet the standards under the Medicare program for home health agencies.

77.34(5) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Nursing facilities, intermediate care facilities for the mentally retarded, or hospitals enrolled as providers in the Iowa Medicaid program.

(3) Respite providers certified under the home- and community-based services intellectual disability or brain injury waiver.

(4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(5) Camps certified by the American Camping Association.

(6) Home care agencies that meet the conditions of participation set forth in subrule 77.34(3).

(7) Adult day care providers that meet the conditions of participation set forth in subrule 77.34(7).

(8) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(9) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian, or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.34(6) *Home-delivered meals.* The following providers may provide home-delivered meals:

a. Home health aide providers meeting the standards set forth in subrule 77.34(2).

b. Home care providers meeting the standards set forth in subrule 77.34(3).

c. Hospitals enrolled as Medicaid providers.

d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

e. Restaurants licensed and inspected under Iowa Code chapter 137F.

f. Community action agencies as designated in Iowa Code section 216A.93. Home-delivered meals providers subcontracting with community action agencies or with letters of approval from the community action agencies stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

g. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

h. Medical equipment and supply dealers certified to participate in the Medicaid program.

77.34(7) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.34(8) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.34(9) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.34(10) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.34(11) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.34(12) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.34(13) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

77.34(14) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS AIDS/HIV waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or to home-delivered meals.

a. Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or

5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.

2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.

2. The date and time the incident occurred.

3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11]

441—77.35(249A) Federally qualified health centers. Federally qualified health centers are eligible to participate in the Medicaid program when the Centers for Medicare and Medicaid Services has notified the Medicaid program of their eligibility as allowed by Section 6404(b) of Public Law 101-239.

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

441—77.36(249A) Advanced registered nurse practitioners. Advanced registered nurse practitioners are eligible to participate in the Medicaid program if they are duly licensed and registered by the state of

Iowa as advanced registered nurse practitioners certified pursuant to board of nursing rules 655—Chapter 7.

77.36(1) Advanced registered nurse practitioners in another state shall be eligible to participate if they are duly licensed and registered in that state as advanced registered nurse practitioners with certification in a practice area consistent with board of nursing rules 655—Chapter 7.

77.36(2) Advanced registered nurse practitioners who have been certified eligible to participate in Medicare shall be considered as having met these guidelines.

77.36(3) Licensed nurse anesthetists who have graduated from a nurse anesthesia program meeting the standards set forth by a national association of nurse anesthetists within the past 18 months and who are awaiting initial certification by a national association of nurse anesthetists approved by the board of nursing shall be considered as having met these guidelines.

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

441—77.37(249A) Home- and community-based services intellectual disability waiver service providers. Providers shall be eligible to participate in the Medicaid HCBS intellectual disability waiver program if they meet the requirements in this rule and the subrules applicable to the individual service.

The standards in subrule 77.37(1) apply only to providers of supported employment, respite providers certified according to subparagraph 77.37(15)*"a"*(8), and providers of supported community living services that are not residential-based. The standards and certification processes in subrules 77.37(2) through 77.37(7) and 77.37(9) through 77.37(12) apply only to supported employment providers and non-residential-based supported community living providers.

The requirements in subrule 77.37(13) apply to all providers. EXCEPTION: A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to the review requirements in subrule 77.37(13). Also, services must be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

77.37(1) *Organizational standards (Outcome 1).* Organizational outcome-based standards for home- and community-based services intellectual disability providers are as follows:

a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.

b. The organization demonstrates a defined mission commensurate with consumer's needs, desires, and abilities.

c. The organization establishes and maintains fiscal accountability.

d. The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.

e. The organization provides needed training and supports to its staff. This training includes at a minimum:

(1) Consumer rights.

(2) Confidentiality.

(3) Provision of consumer medication.

(4) Identification and reporting of child and dependent adult abuse.

(5) Individual consumer support needs.

f. The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

(1) Measures and assesses organizational activities and services annually.

(2) Gathers information from consumers, family members, and staff.

(3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).

(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.

(5) Identifies areas in need of improvement.

(6) Develops a plan to address the areas in need of improvement.

(7) Implements the plan and documents the results.

g. Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The governing body has an active role in the administration of the agency.

j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

77.37(2) *Rights and dignity.* Outcome-based standards for rights and dignity are as follows:

a. (Outcome 2) Consumers are valued.

b. (Outcome 3) Consumers live in positive environments.

c. (Outcome 4) Consumers work in positive environments.

d. (Outcome 5) Consumers exercise their rights and responsibilities.

e. (Outcome 6) Consumers have privacy.

f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.

g. (Outcome 8) Consumers decide which personal information is shared and with whom.

h. (Outcome 9) Consumers make informed choices about where they work.

i. (Outcome 10) Consumers make informed choices on how they spend their free time.

j. (Outcome 11) Consumers make informed choices about where and with whom they live.

k. (Outcome 12) Consumers choose their daily routine.

l. (Outcome 13) Consumers are a part of community life and perform varied social roles.

m. (Outcome 14) Consumers have a social network and varied relationships.

n. (Outcome 15) Consumers develop and accomplish personal goals.

o. (Outcome 16) Management of consumers' money is addressed on an individualized basis.

p. (Outcome 17) Consumers maintain good health.

q. (Outcome 18) The consumer's living environment is reasonably safe in the consumer's home and community.

r. (Outcome 19) The consumer's desire for intimacy is respected and supported.

s. (Outcome 20) Consumers have an impact on the services they receive.

77.37(3) *Contracts with consumers.* The provider shall have written procedures which provide for the establishment of an agreement between the consumer and the provider.

a. The agreement shall define the responsibilities of the provider and the consumer, the rights of the consumer, the services to be provided to the consumer by the provider, all room and board and copay fees to be charged to the consumer and the sources of payment.

b. Contracts shall be reviewed at least annually.

77.37(4) *The right to appeal.* Consumers and their legal representatives have the right to appeal the provider's application of policies or procedures, or any staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

77.37(5) *Storage and provision of medication.* If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the

storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

If the provider has a physician on staff or under contract, the physician shall review and document the provider's prescribed medication regime at least annually in accordance with current medical practice.

77.37(6) *Research.* If the provider conducts research involving human subjects, the provider shall have written policies and procedures for research which ensure the rights of consumers and staff.

77.37(7) *Abuse reporting requirements.* The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

77.37(8) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS intellectual disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation.

a. Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff consumer's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.

2. The date and time the incident occurred.

3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.37(9) *Intake, admission, service coordination, discharge, and referral.*

a. The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral. Service coordination means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

b. The provider shall ensure the rights of persons applying for services.

77.37(10) *Certification process.* Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services' bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

a. Rescinded IAB 9/1/04, effective 11/1/04.

b. Rescinded IAB 9/1/04, effective 11/1/04.

c. Rescinded IAB 9/1/04, effective 11/1/04.

d. The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:

(1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.

(2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

(3) The prospective provider's written agreement to work cooperatively with the state and central point of coordination in the counties and the state to be served by the provider.

77.37(11) *Initial certification.* The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual

consent of the parties involved. Providers shall be responsible for notifying the appropriate county and the appropriate central point of coordination of the determination.

b. The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

(3) The prospective provider's coordination of service design, development, and application with the applicable local county central point of coordination and other interested parties.

c. Providers applying for initial certification shall be offered technical assistance.

77.37(12) *Period of certification.* Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and significant people in the consumer's life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.37(1) and 77.37(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

c. The department may issue four categories of recertification:

(1) *Three-year certification with excellence.* An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) *Three-year certification with follow-up monitoring.* An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together are 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment

of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) *One-year certification.* An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) *Probational certification.* A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended, and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

d. During the course of the review, if a team member encounters a situation that places a consumer in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a consumer will be severely jeopardized if the circumstances are not immediately corrected. The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the notification shall not be certified. The department, the county of residence, and the central point of coordination shall be notified immediately to discontinue funding for that provider's service. If this action is appealed and the consumer, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the consumers deemed to be at risk as a result of the provider's inaction.

e. As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

f. The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

g. The department may revoke the provider's approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13)*"e."*

(2) The provider has failed to provide information requested pursuant to paragraph 77.37(13)*"f."*

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13)*"h."*

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department, applicable county, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from an home- and community-based services intellectual disability waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided

to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

77.37(13) *Review of providers.* Reviews of compliance with standards as indicated in this chapter shall be conducted by designated members of the HCBS staff.

a. This review may include on-site case record audits; review of administrative procedures, clinical practices, personnel records, performance improvement systems and documentation; and interviews with staff, consumers, the board of directors, or others deemed appropriate, consistent with the confidentiality safeguards of state and federal laws.

b. A review visit shall be scheduled with the provider with additional reviews conducted at the discretion of the department.

c. The on-site review team will consist of designated members of the HCBS staff.

d. Following a certification review, the certification review team leader shall submit a copy of the department's written report of findings to the provider within 30 working days after completion of the certification review.

e. The provider shall develop a plan of corrective action, if applicable, identifying completion time frames for each review recommendation.

f. Providers required to make corrective actions and improvements shall submit the corrective action and improvement plan to the Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 30 working days after the receipt of a report issued as a result of the review team's visit. The corrective actions may include: specific problem areas cited, corrective actions to be implemented by the provider, dates by which each corrective measure will be completed, and quality assurance and improvement activities to measure and ensure continued compliance.

g. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to 77.37(13)*"e"* and 77.37(13)*"f."*

h. The department may conduct a site visit to verify all or part of the information submitted.

77.37(14) *Supported community living providers.*

a. The department will contract only with public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113.

d. All supported community living providers shall meet the following requirements:

(1) The provider shall demonstrate how the provider will meet the outcomes and processes in rule 441—77.37(249A) for each of the consumers being served. The provider shall supply timelines showing how the provider will come into compliance with rules 441—77.37(249A), 441—78.41(249A), and 441—83.60(249A) to 441—83.70(249A) and 441—subrule 79.1(15) within one year of certification. These timelines shall include:

1. Implementation of necessary staff training and consumer input.

2. Implementation of provider system changes to allow for flexibility in staff duties, services based on what each individual needs, and removal of housing as part of the service.

(2) The provider shall demonstrate that systems are in place to measure outcomes and processes for individual consumers before certification can be given.

e. The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.

f. The department shall approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of supported community living units in a geographic area.

(2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need;
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

77.37(15) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(2) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

(4) Home health agencies that are certified to participate in the Medicare program.

(5) Camps certified by the American Camping Association.

(6) Adult day care providers that meet the conditions of participation set forth in subrule 77.37(25).

(7) Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

(8) Agencies certified by the department to provide respite services in the consumer's home that meet the requirements of 77.37(1) and 77.37(3) through 77.37(9).

(9) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(10) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
2. An emergency medical care release.
3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.
4. The consumer's medical issues, including allergies.
5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.37(16) *Supported employment providers.*

a. The following agencies may provide supported employment services:

(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider, or a provider of a similar service.

(2) An agency that is accredited by the Council on Accreditation of Services for Families and Children for similar services.

(3) An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations for similar services.

(4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities for similar services.

(5) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Member vacation, sick leave and holiday compensation.

(2) Procedures for payment schedules and pay scale.

(3) Procedures for provision of workers' compensation insurance.

(4) Procedures for the determination and review of commensurate wages.

c. The department will contract only with public or private agencies to provide supported employment services. The department does not recognize individuals as service providers under the supported employment program.

77.37(17) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Providers certified to participate as supported community living service providers under the home- and community-based services intellectual disability or brain injury waiver.

b. Providers eligible to participate as home and vehicle modification providers under the elderly or ill and handicapped waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the brain injury waiver.

c. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

77.37(18) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2) to maintain certification.

77.37(19) *Nursing providers.* Nursing providers shall be agencies that are certified to participate in the Medicare program as home health agencies.

77.37(20) *Home health aide providers.* Home health aide providers shall be agencies which are certified to participate in the Medicare program as home health agencies and which have an HCBS agreement with the department.

77.37(21) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.37(22) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Child care facilities, which are defined as child care centers licensed pursuant to 441—Chapter 109, preschools, or child development homes registered pursuant to 441—Chapter 110.

(2) Rescinded IAB 9/1/04, effective 11/1/04.

(3) Rescinded IAB 9/1/04, effective 11/1/04.

(4) Home health agencies certified to participate in the Medicare program.

(5) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.

(3) Not be a usual caregiver of the member.

(4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.37(23) *Residential-based supported community living service providers.*

a. The department shall contract only with public or private agencies to provide residential-based supported community living services.

b. Subject to the requirements of this rule, the following agencies may provide residential-based supported community living services:

(1) Agencies licensed as group living foster care facilities under 441—Chapter 114.

(2) Agencies licensed as residential facilities for mentally retarded children under 441—Chapter 116.

(3) Other agencies providing residential-based supported community living services that meet the following conditions:

1. The agency must provide orientation training on the agency's purpose, policies, and procedures within one month of hire or contracting for all employed and contracted treatment staff and must provide 24 hours of training during the first year of employment or contracting. The agency must also provide at least 12 hours of training per year after the first year of employment for all employed and contracted treatment staff. Annual training shall include, at a minimum, training on children's mental retardation and developmental disabilities services and children's mental health issues.Identification and reporting

of child abuse shall be covered in training at least every five years, in accordance with Iowa Code section 232.69.

2. The agency must have standards for the rights and dignity of children that are age-appropriate. These standards shall include the following:

- Children, their families, and their legal representatives decide what personal information is shared and with whom.
- Children are a part of family and community life and perform varied social roles.
- Children have family connections, a social network, and varied relationships.
- Children develop and accomplish personal goals.
- Children are valued.
- Children live in positive environments.
- Children exercise their rights and responsibilities.
- Children make informed choices about how they spend their free time.
- Children choose their daily routine.

3. The agency must use methods of self-evaluation by which:

- Past performance is reviewed.
- Current functioning is evaluated.
- Plans are made for the future based on the review and evaluation.

4. The agency must have a governing body that receives and uses input from a wide range of local community interests and consumer representatives and provides oversight that ensures the provision of high-quality supports and services to children.

5. Children, their parents, and their legal representatives must have the right to appeal the service provider's application of policies or procedures or any staff person's action that affects the consumer. The service provider shall distribute the policies for consumer appeals and procedures to children, their parents, and their legal representatives.

c. As a condition of participation, all providers of residential-based supported community living services must have the following on file:

(1) Current accreditations, evaluations, inspections, and reviews by applicable regulatory and licensing agencies and associations.

(2) Documentation of the fiscal capacity of the provider to initiate and operate the specified programs on an ongoing basis.

(3) The provider's written agreement to work cooperatively with the department.

d. As a condition of participation, all providers of residential-based supported community living services must develop, review, and revise service plans for each child, as follows:

(1) The service plan shall be developed in collaboration with the social worker or case manager, child, family, and, if applicable, the foster parents, unless a treatment rationale for the lack of involvement of one of these parties is documented in the plan. The service provider shall document the dates and content of the collaboration on the service plan. The service provider shall provide a copy of the service plan to the family and the case manager, unless otherwise ordered by a court of competent jurisdiction.

(2) Initial service plans shall be developed after services have been authorized and within 30 calendar days of initiating services.

(3) The service plan shall identify the following:

1. Strengths and needs of the child.
2. Goals to be achieved to meet the needs of the child.
3. Objectives for each goal that are specific, measurable, and time-limited and include indicators of progress toward each goal.
4. Specific service activities to be provided to achieve the objectives.
5. The persons responsible for providing the services. When daily living and social skills development is provided in a group care setting, designation may be by job title.
6. Date of service initiation and date of individual service plan development.
7. Service goals describing how the child will be reunited with the child's family and community.

(4) Individuals qualified to provide all services identified in the service plan shall review the services identified in the service plan to ensure that the services are necessary, appropriate, and consistent with the identified needs of the child, as listed on Form 470-3273, Mental Retardation Functional Assessment Tool.

(5) The service worker or case manager shall review all service plans to determine progress toward goals and objectives 90 calendar days from the initiation of services and every 90 calendar days thereafter for the duration of the services.

At a minimum, the provider shall submit written reports to the service worker or case manager at six-month intervals and when changes to the service plan are needed.

(6) The individual service plan shall be revised when any of the following occur:

1. Service goals or objectives have been achieved.
2. Progress toward goals and objectives is not being made.
3. Changes have occurred in the identified service needs of the child, as listed on Form 470-3273, Mental Retardation Functional Assessment Tool.
4. The service plan is not consistent with the identified service needs of the child, as listed in the service plan.

(7) The service plan shall be signed and dated by qualified staff of each reviewing provider after each review and revision.

(8) Any revisions of the service plan shall be made in collaboration with the child, family, case manager, and, if applicable, the foster parents and shall reflect the needs of the child. The service provider shall provide a copy of the revised service plan to the family and case manager, unless otherwise ordered by a court of competent jurisdiction.

e. The residential-based supportive community living service provider shall also furnish residential-based living units for all recipients of the residential-based supported community living services. Except as provided herein, living units provided may be of no more than four beds. Service providers who receive approval from the bureau of long-term care may provide living units of up to eight beds. The bureau shall approve five- to eight-bed living units only if all of the following conditions are met:

(1) Rescinded IAB 8/7/02, effective 10/1/02.

(2) There is a need for the service to be provided in a five- to eight-person living unit instead of a smaller living unit, considering the location of the programs in an area.

(3) The provider supplies the bureau of long-term care with a written plan acceptable to the department that addresses how the provider will reduce its living units to four-bed units within a two-year period of time. This written plan shall include the following:

1. How the transition will occur.
2. What physical change will need to take place in the living units.
3. How children and their families will be involved in the transitioning process.
4. How this transition will affect children's social and educational environment.

f. Certification process and review of service providers.

(1) The certification process for providers of residential-based supported community living services shall be pursuant to subrule 77.37(10).

(2) The initial certification of residential-based supported community living services shall be pursuant to subrule 77.37(11).

(3) Period and conditions of certification.

1. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days, effective on the date identified on the certificate of approval, based on documentation provided.
2. Recertification. After the initial certification, recertification shall be based on an on-site review and shall be contingent upon demonstration of compliance with certification requirements.

An exit conference shall be held with the provider to share preliminary findings of the recertification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Recertification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate one year from the month of issuance.

Corrective actions may be required in connection with recertification and may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

3. Probational certification. Probational certification for 270 calendar days may be issued to a provider who cannot demonstrate compliance with all certification requirements on recertification review to give the provider time to establish and implement corrective actions and improvement activities.

During the probational certification period, the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports, or technical assistance.

Probational certification shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider must demonstrate compliance with all certification requirements at the time of the follow-up review in order to maintain certification.

4. Immediate jeopardy. If, during the course of any review, a review team member encounters a situation that places a consumer in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a consumer will be severely jeopardized if the circumstances are not immediately corrected.

The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, the provider shall not be certified. The department, the county of residence, and the central point of coordination shall be notified immediately to discontinue funding for that provider's service. If this action is appealed and the consumer or legal guardian wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the consumers deemed to be at risk.

5. Abuse reporting. As a mandatory reporter, each review team member shall follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

6. Extensions. The department shall establish the length of extensions on a case-by-case basis. The department may grant an extension to the period of certification for the following reasons:

- A delay in the department's approval decision exists which is beyond the control of the provider or department.
- A request for an extension is received from a provider to permit the provider to prepare and obtain department approval of corrective actions.

7. Revocation. The department may revoke the provider's approval at any time for any of the following reasons:

- The findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13)*"e"* and numbered paragraph 77.37(23)*"f"*(3)"4."
- The provider has failed to provide information requested pursuant to paragraph 77.37(13)*"f"* and numbered paragraph 77.37(23)*"f"*(3)"4."
- The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13)*"h"* and subparagraph 77.37(23)*"f"*(3).
- There are instances of noncompliance with the standards that were not identified from information submitted on the application.

8. Notice of intent to withdraw. An approved provider shall immediately notify the department, applicable county, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw as a provider of residential-based supported community living services.

9. Technical assistance. Following certification, any provider may request technical assistance from the department regarding compliance with program requirements. The department may require that technical assistance be provided to a provider to assist in the implementation of any corrective action plan.

10. Appeals. The provider can appeal any adverse action under 441—Chapter 7.

(4) Providers of residential-based supported community living services shall be subject to reviews of compliance with program requirements pursuant to subrule 77.37(13).

77.37(24) *Transportation service providers.* The following providers may provide transportation:

a. Accredited providers of home- and community-based services.

b. Regional transit agencies as recognized by the Iowa department of transportation.

c. Transportation providers that contract with county governments.

d. Community action agencies as designated in Iowa Code section 216A.93.

e. Nursing facilities licensed under Iowa Code chapter 135C.

f. Area agencies on aging as designated in rule 17—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.

77.37(25) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.37(26) *Prevocational services providers.* Providers of prevocational services must be accredited by one of the following:

a. The Commission on Accreditation of Rehabilitation Facilities as a work adjustment service provider or an organizational employment service provider.

b. The Council on Quality and Leadership.

77.37(27) *Day habilitation providers.* Day habilitation services may be provided by:

a. Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation under 441—subrule 78.41(14).

b. Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide other services that began providing services that qualify as day habilitation under 441—subrule 78.41(14) since their last accreditation survey. The agency may provide day habilitation services until the current accreditation expires. When the current accreditation expires, the agency must qualify under paragraph *"a"* or *"d."*

c. Agencies not accredited by the Commission on Accreditation of Rehabilitation Facilities that have applied to the Commission within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.41(14). An agency that has not received accreditation within 12 months after application to the Commission is no longer a qualified provider.

d. Agencies accredited by the Council on Quality and Leadership.

e. Agencies that have applied to the Council on Quality and Leadership for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

77.37(28) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.37(29) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.37(30) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.37(31) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.37(32) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11]

441—77.38(249A) Rehabilitative treatment service providers. Rescinded IAB 8/1/07, effective 9/5/07.

441—77.39(249A) HCBS brain injury waiver service providers. Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Providers and each of their staff members involved in direct consumer service must have training regarding or experience with consumers who have a brain injury, with the exception of providers of home and vehicle modification, specialized medical equipment, transportation, personal emergency response, financial management, independent support brokerage, self-directed personal care, individual-directed goods and services, and self-directed community supports and employment.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

In addition, behavioral programming, supported community living, and supported employment providers shall meet the outcome-based standards set forth below in subrules 77.39(1) and 77.39(2) evaluated according to subrules 77.39(8) to 77.39(10), and the requirements of subrules 77.39(3) to 77.39(7). Respite providers shall also meet the standards in subrule 77.39(1).

77.39(1) *Organizational standards (Outcome 1).* Organizational outcome-based standards for HCBS BI providers are as follows:

a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.

b. The organization demonstrates a defined mission commensurate with consumers' needs, desires, and abilities.

c. The organization establishes and maintains fiscal accountability.

d. The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.

e. The organization provides needed training and supports to its staff. This training includes at a minimum:

(1) Consumer rights.

(2) Confidentiality.

(3) Provision of consumer medication.

(4) Identification and reporting of child and dependent adult abuse.

(5) Individual consumer support needs.

f. The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

(1) Measures and assesses organizational activities and services annually.

(2) Gathers information from consumers, family members, and staff.

(3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).

(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.

(5) Identifies areas in need of improvement.

(6) Develops a plan to address the areas in need of improvement.

(7) Implements the plan and documents the results.

g. Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The governing body has an active role in the administration of the agency.

j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

77.39(2) *Rights and dignity.* Outcome-based standards for rights and dignity are as follows:

a. (Outcome 2) Consumers are valued.

b. (Outcome 3) Consumers live in positive environments.

c. (Outcome 4) Consumers work in positive environments.

d. (Outcome 5) Consumers exercise their rights and responsibilities.

e. (Outcome 6) Consumers have privacy.

f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.

g. (Outcome 8) Consumers decide which personal information is shared and with whom.

h. (Outcome 9) Consumers make informed choices about where they work.

i. (Outcome 10) Consumers make informed choices on how they spend their free time.

j. (Outcome 11) Consumers make informed choices about where and with whom they live.

k. (Outcome 12) Consumers choose their daily routine.

l. (Outcome 13) Consumers are a part of community life and perform varied social roles.

m. (Outcome 14) Consumers have a social network and varied relationships.

n. (Outcome 15) Consumers develop and accomplish personal goals.

o. (Outcome 16) Management of consumers' money is addressed on an individualized basis.

p. (Outcome 17) Consumers maintain good health.

q. (Outcome 18) The consumer's living environment is reasonably safe in the consumer's home and community.

r. (Outcome 19) The consumer's desire for intimacy is respected and supported.

s. (Outcome 20) Consumers have an impact on the services they receive.

77.39(3) *The right to appeal.* Consumers and their legal representatives have the right to appeal the provider's application of policies or procedures, or any staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

77.39(4) *Storage and provision of medication.* If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

77.39(5) *Research.* If the provider conducts research involving consumers, the provider shall have written policies and procedures addressing the research. These policies and procedures shall ensure that consumers' rights are protected.

77.39(6) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS brain injury waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation.

a. Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the

incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.39(7) *Intake, admission, service coordination, discharge, and referral.*

a. The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral.

b. The provider shall ensure the rights of persons applying for services.

77.39(8) *Certification process.* Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services' bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

a. Rescinded IAB 9/1/04, effective 11/1/04.

b. Rescinded IAB 9/1/04, effective 11/1/04.

c. Rescinded IAB 9/1/04, effective 11/1/04.

d. The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:

(1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.

(2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

(3) The prospective provider's written agreement to work cooperatively with the state and central point of coordination in the counties and the state to be served by the provider.

77.39(9) *Initial certification.* The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved. Providers shall be responsible for notifying the appropriate county and the appropriate central point of coordination of the determination.

b. The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

(3) The prospective provider's coordination of service design, development, and application with the applicable local county central point of coordination and other interested parties.

c. Providers applying for initial certification shall be offered technical assistance.

77.39(10) *Period of certification.* Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and significant people in the consumer's life to determine whether or not the 20 individual value-based

outcomes set forth in subrules 77.39(1) and 77.39(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

c. The department may issue four categories of recertification:

(1) *Three-year certification with excellence.* An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) *Three-year certification with follow-up monitoring.* An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together is 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) *One-year certification.* An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes present together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) *Probational certification.* A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

d. During the course of the review, if a team member encounters a situation that places a consumer in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a consumer will be severely jeopardized if the circumstances are not immediately corrected. The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the notification shall not be certified. The department, the county of residence, and the central point of coordination shall

be notified immediately to discontinue funding for that provider's service. If this action is appealed and the consumer, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the consumers deemed to be at risk as a result of the provider's inaction.

e. As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

f. The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

g. The department may revoke the provider's approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.39(11)*"d."*

(2) The provider has failed to provide information requested pursuant to paragraph 77.39(11)*"e."*

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.39(11)*"f."*

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department, applicable county, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from an HCBS BI waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

77.39(11) *Departmental reviews.* Reviews of compliance with standards as indicated in this chapter shall be conducted by the division of mental health and developmental disabilities quality assurance review staff. This review may include on-site case record audits, administrative procedures, clinical practices, and interviews with staff, consumers, and board of directors consistent with the confidentiality safeguards of state and federal laws.

a. Reviews shall be conducted annually with additional reviews conducted at the discretion of the department.

b. Following a departmental review, the department shall submit a copy of the department's determined survey report to the service provider, noting service deficiencies and strengths.

c. The service provider shall develop a plan of corrective action identifying completion time frames for each survey deficiency.

d. The corrective action plan shall be submitted to the Division of Mental Health and Developmental Disabilities, 5th Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114, and include a statement dated and signed, if applicable, by the chief administrative officer and president or chairperson of the governing body that all information submitted to the department is accurate and complete.

e. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to paragraphs 77.39(11)*"c"* and *"d."*

f. The department may conduct a site visit to verify all or part of the information submitted.

77.39(12) *Case management service providers.* Case management provider organizations are eligible to participate in the Medicaid HCBS brain injury waiver program provided that they meet the

standards in 441—Chapter 24 and they are the department of human services, a county or consortium of counties, or a provider under subcontract to the department or a county or consortium of counties.

77.39(13) *Supported community living providers.*

a. The department shall certify only public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116, which deal with foster care licensing.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113, which deal with foster care licensing.

d. The department shall approve living units designed to serve four consumers if the geographic location of the program does not result in an overconcentration of programs in an area.

(1) and (2) Rescinded IAB 8/7/02, effective 10/1/02.

e. The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.

f. The department shall approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of supported community living units in a geographic area.

(2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need;
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

77.39(14) *Respite service providers.* Respite providers are eligible to be providers of respite service in the HCBS brain injury waiver if they have documented training or experience with persons with a brain injury.

a. The following agencies may provide respite services:

(1) Respite providers certified under the HCBS intellectual disability waiver.

(2) Adult day care providers that meet the conditions of participation set forth in subrule 77.39(20).

(3) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(4) Camps certified by the American Camping Association.

(5) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).

(6) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(7) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

(8) Home health agencies that are certified to participate in the Medicare program.

(9) Agencies certified by the department to provide respite services in the consumer's home that meet the requirements of subrules 77.39(1) and 77.39(3) through 77.39(7).

(10) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(11) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
2. An emergency medical care release.
3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.39(15) *Supported employment providers.*

a. The following agencies may provide supported employment services:

(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider or a provider of a similar service.

(2) An agency that is accredited by the Council on Accreditation of Services for Families and Children for similar services.

(3) An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations for similar services.

(4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities for similar services.

(5) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Member vacation, sick leave and holiday compensation.

(2) Procedures for payment schedules and pay scale.

(3) Procedures for provision of workers' compensation insurance.

(4) Procedures for the determination and review of commensurate wages.

c. The department will contract only with public or private agencies to provide supported employment services. The department does not recognize individuals as service providers under the supported employment program.

77.39(16) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Providers eligible to participate as home and vehicle modification providers under the elderly or ill and handicapped waiver, enrolled as home and vehicle modification providers under the physical

disability waiver, or certified as home and vehicle modification providers under the physical disability waiver.

b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

77.39(17) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

a. Providers shall be certified annually.

b. The service provider shall submit documentation to the department supporting continued compliance with the requirements set forth in subrule 77.33(2) 90 days before the expiration of the current certification.

77.39(18) *Transportation service providers.* This service is not to be provided at the same time as supported community service, which includes transportation. The following providers may provide transportation:

a. Area agencies on aging as designated in rule 17—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Providers with purchase of service contracts to provide transportation pursuant to 441—Chapter 150.

e. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

77.39(19) *Specialized medical equipment providers.* The following providers may provide specialized medical equipment:

a. Medical equipment and supply dealers participating as providers in the Medicaid program.

b. Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.43(8).

77.39(20) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.39(21) *Family counseling and training providers.* Family counseling and training providers shall be one of the following:

a. Providers certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

b. Providers licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules in 481—Chapter 53 or certified to meet the standards under the Medicare program for hospice programs, and that employ staff who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

c. Providers accredited under the mental health service provider standards established by the mental health and developmental and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

d. Individuals who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

e. Agencies certified as brain injury waiver providers pursuant to rule 441—77.39(249A) that employ staff to provide family counseling who meet the definition of a qualified brain injury professional as set forth in rule 441—83.81(249A).

77.39(22) *Prevocational services providers.* Providers of prevocational services must meet the Commission on Accreditation of Rehabilitation Facilities standards for work adjustment service providers.

77.39(23) *Behavioral programming providers.* Behavioral programming providers shall be required to have experience with or training regarding the special needs of persons with a brain injury. In addition, they must meet the following requirements.

a. Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional as defined in rule 441—83.81(249A). Formal assessment of the consumers' intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.

b. Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441—83.81(249A) and who are employees of one of the following:

(1) Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

(2) Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

(3) Agencies which are accredited under the mental health service provider standards established by the mental health and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

(4) Home health aide providers meeting the standards set forth in subrule 77.33(3). Home health aide providers certified by Medicare shall be considered to have met these standards.

(5) Brain injury waiver providers certified pursuant to rule 441—77.39(249A).

77.39(24) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.39(25) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Child care facilities, which are defined as child care centers licensed pursuant to 441—Chapter 109, preschools, or child development homes registered pursuant to 441—Chapter 110.

(2) Rescinded IAB 9/1/04, effective 11/1/04.

(3) Rescinded IAB 9/1/04, effective 11/1/04.

(4) Home health agencies certified to participate in the Medicare program.

(5) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.

(3) Not be a usual caregiver of the member.

(4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.39(26) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.39(27) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.39(28) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.39(29) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.39(30) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11]

441—77.40(249A) Lead inspection agencies. The Iowa department of public health and agencies certified by the Iowa department of public health pursuant to 641—subrule 70.5(5) are eligible to participate in the Medicaid program as providers of lead inspection services.

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

441—77.41(249A) HCBS physical disability waiver service providers. Providers shall be eligible to participate in the Medicaid physical disability waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Enrolled providers shall maintain the certification listed in the applicable subrules in order to remain eligible providers.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to the requirements of subrule 77.41(1).

77.41(1) *Enrollment process.* Reviews of compliance with standards for initial enrollment shall be conducted by the department's quality assurance staff. Enrollment carries no assurance that the approved provider will receive funding.

Review of a provider may occur at any time.

The department may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This may include, but is not limited to:

a. Current accreditations, evaluations, inspection reports, and reviews by regulatory and licensing agencies and associations.

b. Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

c. The prospective provider's written agreement to work cooperatively with the state and central point of coordination in the counties to be served by the provider.

77.41(2) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide consumer-directed attendant care and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies that are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.103.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.41(3) *Home and vehicle modification providers.* The following providers may provide home and vehicle modifications:

a. Providers eligible to participate as home and vehicle modification providers under the elderly or ill and handicapped waiver or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.

b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

77.41(4) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

77.41(5) *Specialized medical equipment providers.* The following providers may provide specialized medical equipment:

a. Medical equipment and supply dealers participating as providers in the Medicaid program.

b. Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.46(4).

77.41(6) *Transportation service providers.* The following providers may provide transportation:

a. Area agencies on aging as designated in 17—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

77.41(7) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.41(8) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.41(9) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.41(10) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.41(11) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the subrule requirements in 77.30(17).

77.41(12) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS physical disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, specialized medical equipment, personal emergency response, and transportation.

a. Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.

2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.

2. The date and time the incident occurred.

3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11]

441—77.42(249A) Rehabilitation services to adults with chronic mental illness providers. Rescinded IAB 8/1/07, effective 9/5/07.

441—77.43(249A) Infant and toddler program providers. An agency is eligible to participate in the medical assistance program as a provider of infant and toddler program services under rule 441—78.49(249A) if the agency:

1. Is in good standing under the infants and toddlers with disabilities program administered by the department of education, the department of public health, the department of human services, and the Iowa Child Health Specialty Clinics pursuant to the interagency agreement between these agencies under Subchapter III of the federal Individuals with Disabilities Education Act (IDEA); and

2. Meets the following additional requirements.

77.43(1) *Licensure.* Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

a. Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

b. Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

c. Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(2) Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

(3) Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

(4) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(5) Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

e. Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

f. Personnel providing vision services shall be:

(1) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;

(2) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(3) Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

g. Developmental services shall be provided by personnel who meet standards established pursuant to department of education rule 281—120.19(34CFR303).

h. Medical transportation shall be provided by licensed drivers.

i. Other services shall be provided by staff who are:

(1) Recognized as a special education paraprofessional pursuant to department of education rule 281—41.403(256B);

(2) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(3) Endorsed by the Iowa board of educational examiners as a speech-language pathologist pursuant to rule 282—15.12(272);

(4) Endorsed by the Iowa board of educational examiners as an orientation and mobility specialist pursuant to rule 282—15.15(272);

(5) Endorsed by the Iowa board of educational examiners as a school occupational therapist pursuant to rule 282—15.16(272);

(6) Endorsed by the Iowa board of educational examiners as a school physical therapist pursuant to rule 282—15.17(272);

(7) Endorsed by the Iowa board of educational examiners as a special education nurse pursuant to rule 282—15.18(272);

(8) Endorsed by the Iowa board of educational examiners as a school social worker pursuant to rule 282—15.19(272);

(9) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6; or

(10) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11.

77.43(2) *Documentation requirements.* As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation of services provided in the child's record. Documentation of all services performed is required and must include:

a. Date, time, location, and description of each service provided and identification of the individual rendering the service by name and professional or paraprofessional designation.

b. An assessment and response to interventions and services.

c. An individual family service plan (IFSP) including all changes and revisions, as developed by the service coordinator pursuant to rule 281—41.5(256B,34CFR300).

d. Documentation of progress toward achieving the child's or family's action steps and outcomes as identified in the individual family service plan (IFSP).

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

441—77.44(249A) Local education agency services providers. School districts accredited by the department of education pursuant to 281—Chapter 12, the Iowa Braille and Sight Saving School governed by the state board of regents pursuant to Iowa Code section 262.7(4), and the State School for the Deaf governed by the state board of regents pursuant to Iowa Code section 262.7(5) are eligible to participate in the medical assistance program as providers of local education agency (LEA) services under rule 441—78.50(249A) if the following conditions are met.

77.44(1) *Licensure.* Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

a. Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

b. Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

c. Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(2) Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

(3) Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

(4) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(5) Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

e. Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

f. Personnel providing vision services shall be:

(1) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;

(2) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(3) Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

g. Developmental services shall be provided by personnel who meet standards established pursuant to department of education rule 281—120.19(34CFR303).

h. Medical transportation shall be provided by licensed drivers.

i. Other services shall be provided by staff who are:

(1) Recognized as a special education paraprofessional pursuant to department of education rule 281—41.403(256B);

(2) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(3) Endorsed by the Iowa board of educational examiners as a speech-language pathologist pursuant to rule 282—15.12(272);

(4) Endorsed by the Iowa board of educational examiners as an orientation and mobility specialist pursuant to rule 282—15.15(272);

(5) Endorsed by the Iowa board of educational examiners as a school occupational therapist pursuant to rule 282—15.16(272);

(6) Endorsed by the Iowa board of educational examiners as a school physical therapist pursuant to rule 282—15.17(272);

(7) Endorsed by the Iowa board of educational examiners as a special education nurse pursuant to rule 282—15.18(272);

(8) Endorsed by the Iowa board of educational examiners as a school social worker pursuant to rule 282—15.19(272);

(9) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6; or

(10) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11.

77.44(2) *Documentation requirements.* As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation in the child's record. Documentation of all services performed is required and must include:

a. Date, time, duration, location, and description of each service delivered and identification of the individual rendering the service by name and professional or paraprofessional designation.

b. An assessment and response to interventions and services.

c. Progress toward goals in the individual education plan (IEP) or individual health plan (IHP) pursuant to 281—Chapter 41, Division VIII, or 281—subrule 41.96(1).

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

441—77.45(249A) Indian health service 638 facilities. A health care facility owned and operated by American Indian or Alaskan native tribes or tribal organizations with funding authorized by Title I or Title III of the Indian Self-Determination and Education Assistance Act (P.L. 93-638) is eligible to participate in the medical assistance program if the following conditions are met:

77.45(1) *Licensure.* Services must be rendered by practitioners who meet applicable professional licensure requirements.

77.45(2) *Documentation.* Medical records must be maintained at the same standards as are required for the applicable licensed medical practitioner.

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

441—77.46(249A) HCBS children's mental health waiver service providers. HCBS children's mental health waiver services shall be rendered by provider agencies that meet the general provider standards in subrule 77.46(1) and also meet the standards in subrules 77.46(2) to 77.46(5) that are specific to the waiver services provided. A provider that is approved for the same service under another HCBS Medicaid waiver shall be eligible to enroll for that service under the children's mental health waiver.

77.46(1) *General provider standards.* All providers of HCBS children's mental health waiver services shall meet the following standards:

a. Fiscal capacity. Providers must demonstrate the fiscal capacity to provide services on an ongoing basis.

b. Direct care staff.

(1) Direct care staff must be at least 18 years of age.

(2) Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employment of a staff member who will provide direct care.

(3) Direct care staff may not be the spouse of the consumer or the parent or stepparent of the consumer.

c. Outcome-based standards and quality assurance.

(1) Providers shall implement the following outcome-based standards for the rights and dignity of children with serious emotional disturbance:

1. Consumers are valued.
2. Consumers are a part of community life.
3. Consumers develop meaningful goals.
4. Consumers maintain physical and mental health.
5. Consumers are safe.
6. Consumers and their families have an impact on the services received.

(2) The department's quality assurance staff shall conduct random quality assurance reviews to assess the degree to which the outcome-based standards have been implemented in service provision. Results of outcome-based quality assurance reviews shall be forwarded to the certifying or accrediting entity.

(3) A quality assurance review shall include interviews with the consumer and the consumer's parents or legal guardian, with informed consent, and interviews with designated targeted case managers.

(4) A quality assurance review may include interviews with provider staff, review of case files, review of staff training records, review of compliance with the general provider standards in this subrule, and review of other organizational policies and procedures and documentation.

(5) Corrective action shall be required if the quality assurance review demonstrates that service provision or provider policies and procedures do not reflect the outcome-based standards. Technical assistance for corrective action shall be available from the department's quality assurance staff.

d. Incident management and reporting. As a condition of participation in the medical assistance program, HCBS children's mental health waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and must comply with the following incident management and reporting requirements. EXCEPTION: The conditions in this paragraph do not apply to providers of environmental modifications and adaptive devices.

(1) Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

(2) Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

(3) Notification procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident, the staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.

2. The consumer or the consumer's legal guardian. EXEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The consumer's case manager.

(4) Reporting procedure for major incidents. By the end of the next calendar day after a major incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(5) Information to be reported. The following information shall be reported about a major incident:

1. The name of the consumer involved.

2. The date and time the incident occurred.

3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(6) Response to report. Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about a major incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

(7) Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.46(2) *Environmental modifications, adaptive devices, and therapeutic resources providers.* The following agencies may provide environmental modifications, adaptive devices, and therapeutic resources under the children's mental health waiver:

a. A community business that:

(1) Possesses all necessary licenses and permits to operate in conformity with federal, state, and local statutes and regulations, including Iowa Code chapter 490; and

(2) Submits verification of current liability and workers' compensation insurance.

b. A retail or wholesale business that otherwise participates as a provider in the Medicaid program.

c. A home and vehicle modification provider enrolled under another HCBS Medicaid waiver.

d. A provider enrolled under the HCBS home- and community-based services intellectual disability or brain injury waiver as a supported community living provider.

e. A provider enrolled under the HCBS children's mental health waiver as a family and community support services provider.

77.46(3) *Family and community support services providers.*

a. Qualified providers. The following agencies may provide family and community support services under the children's mental health waiver:

(1) Remedial services providers qualified under 441—77.12(249A).

(2) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

b. Staff training. The agency shall meet the following training requirements as a condition of providing family and community support services under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.36(1)*"c"* for the children's mental health waiver.

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;

5. Incident reporting;

6. Documentation of service provision;

7. Appropriate behavioral interventions; and

8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

c. Support of crisis intervention plan. As a condition of providing services under the children's mental health waiver, a family and community support provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

d. Intake, admission, and discharge. As a condition of providing services under the children's mental health waiver, a family and community support provider shall have written policies and procedures for intake, admission, and discharge.

77.46(4) *In-home family therapy providers.*

a. Qualified providers. The following agencies may provide in-home family therapy under the children's mental health waiver:

(1) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

(2) Mental health professionals licensed pursuant to 645—Chapter 31, 240, or 280 or possessing an equivalent license in another state.

b. Staff training. The agency shall meet the following training requirements as a condition of providing in-home family therapy under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.46(1)*"c"* for the children's mental health waiver.

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and service provision to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;

5. Incident reporting;

6. Documentation of service provision;

7. Appropriate behavioral interventions; and

8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

c. Support of crisis intervention plan. As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

d. Intake, admission, and discharge. As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall have written policies and procedures for intake, admission, and discharge.

77.46(5) *Respite care providers.*

a. Qualified providers. The following agencies may provide respite services under the children's mental health waiver:

(1) Providers certified or enrolled as respite providers under another Medicaid HCBS waiver.

(2) Group living foster care facilities for children licensed in good standing by the department according to 441—Chapters 112 and 114 to 116.

(3) Child care centers licensed in good standing by the department according to 441—Chapter 109 and child development homes registered according to 441—Chapter 110.

(4) Camps certified in good standing by the American Camping Association.

(5) Home health agencies that are certified in good standing to participate in the Medicare program.

(6) Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

(7) Adult day care providers that are certified in good standing by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

(8) Assisted living programs certified in good standing by the department of inspections and appeals.

(9) Residential care facilities for persons with mental retardation licensed in good standing by the department of inspections and appeals.

(10) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

b. Staff training. The agency shall meet the following training requirements as a condition of providing respite care under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity for the children's mental health waiver in 77.46(1)*"c."*

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;

5. Incident reporting;

6. Documentation of service provision;

7. Appropriate behavioral interventions; and

8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the oversight of supervisory staff and shall obtain feedback from the family within 24 hours of service provision.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

c. Consumer-specific information. The following information must be written, current, and accessible to the respite provider during service provision:

(1) The consumer's legal and preferred name, birth date, and age, and the address and telephone number of the consumer's usual residence.

(2) The consumer's typical schedule.

(3) The consumer's preferences in activities and foods or any other special concerns.

(4) The consumer's crisis intervention plan.

d. Written notification of injury. The respite provider shall inform the parent, guardian or usual caregiver that written notification must be given to the respite provider of any recent injuries or illnesses that have occurred before respite provision.

e. Medication dispensing. Respite providers shall develop policies and procedures for the dispensing, storage, and recording of all prescription and nonprescription medications administered during respite provision. Home health agencies must follow Medicare regulations regarding medication dispensing.

f. Support of crisis intervention plan. As a condition of providing services under the children's mental health waiver, a respite provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

g. Service documentation. Documentation of respite care shall be made available to the consumer, parents, guardian, or usual caregiver upon request.

h. Capacity. A facility providing respite care under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in a location and for a duration consistent with the facility's licensure.

i. Service provided outside home or facility. For respite care to be provided in a location other than the consumer's home or the provider's facility:

(1) The care must be approved by the parent, guardian or usual caregiver;

(2) The care must be approved by the interdisciplinary team in the consumer's service plan;

(3) The care must be consistent with the way the location is used by the general public; and

(4) Respite care in these locations shall not exceed 72 continuous hours.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

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1 December 15, 2002, effective date of 77.37(14)*"e"*(2) and 77.39(13)*"e"* delayed 70 days by the Administrative Rules Review Committee at its meeting held December 10, 2002; at its meeting held February 21, 2003, the Committee delayed the effective date until adjournment of the 2003 Session of the General Assembly.

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, therapeutically certified 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. Payment will not be made for biological supplies and drugs provided free of charge to practitioners by the state department of public health. Rate of payment shall be established as in subrule 78.2(2), but no professional fee shall be paid.

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

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

d. Acupuncture treatments.

e. Rescinded 9/6/78.

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

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

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. All physicians who administer vaccines which are available through the Vaccines for Children program to Medicaid members shall enroll in the Vaccines for Children program. Vaccines available through the Vaccines for Children program shall be obtained from the department of public health for Medicaid members. Physicians shall, however, receive reimbursement for the administration of these vaccines to Medicaid members.

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 will not be approved for vaccines which are available through 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.

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 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 subrule 81.13(13)*"e."* On-site supervision of the physician is not required for these services.

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

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

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

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

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

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

(1) Is able to control the manner in which the work is performed, i.e., is able to control when, where and how the work is done. This control need not be actually exercised by the physician.

(2) Sets work standards.

(3) Establishes job description.

(4) Withholds taxes from the wages of the auxiliary personnel.

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

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

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

A physician assistant licensed under board of physician assistants' professional licensure rules in 645—Chapter 325 is exempt from the direct personal supervision requirement but the physician must still provide general supervision and be available to provide immediate needed assistance by telephone.

Physician assistants who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

d. Services incident to the professional services of the physician means the service provided by the auxiliary person must be related to the physician's professional service to the member. If the physician has not or will not perform a personal professional service to the member, the clinical records must document that the physician assigned treatment of the member to the auxiliary person.

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

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

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

a. The following definitions are pertinent to this subrule:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

f. At least 30 days and not more than 180 days shall have elapsed following the signing of the informed consent except in the case of premature delivery or emergency abdominal surgery which occurs not less than 72 hours after the informed consent was signed. The informed consent shall have been signed at least 30 days before the expected delivery date for premature deliveries.

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

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

(1) The person to be sterilized,

(2) The interpreter, when one was necessary,

(3) The physician, and

(4) The person who provided the required information.

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

(1) In labor or childbirth, or

(2) Seeking to obtain or obtaining an abortion, or

(3) Under the influence of alcohol or other substance that affects the individual's state of awareness.

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

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

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

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

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

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

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

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

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

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

78.1(19) Preprocedure review by the Iowa Foundation for Medical Care (IFMC) will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review

applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and the published criteria established by the IFMC and the department. If not so approved by the IFMC, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

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

78.1(20) Transplants.

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

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

(2) Allogeneic bone marrow transplants for the treatment of aplastic anemia, severe combined immunodeficiency disease, Wiskott-Aldrich syndrome, or the following types of leukemia: acute myelocytic leukemia in relapse or remission, chronic myelogenous leukemia, and acute lemphocytic leukemia in remission.

(3) Autologous bone marrow transplants for treatment of the following conditions: acute leukemia in remission with a high probability of relapse when there is no matched donor; resistant non-Hodgkin's lymphomas; lymphomas presenting poor prognostic features; recurrent or refractory neuroblastoma; or advanced Hodgkin's disease when conventional therapy has failed and there is no matched donor.

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

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

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

(5) Heart transplants. Artificial hearts and ventricular assist devices, either as a permanent replacement for a human heart or as a temporary life-support system until a human heart becomes available for transplants, 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 and heart-lung transplants described above require preprocedure review by the Iowa Foundation for Medical Care. (Cross-reference 78.1(19) and 78.28(1)*"f."*) Covered heart transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[**ARC 8714B**, IAB 5/5/10, effective 5/1/10]

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, therapeutically certified optometrist, physician assistant, or advanced registered nurse practitioner).

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 to cause anorexia, weight gain, or weight loss, except for lipase inhibitor drugs prescribed for weight loss with prior authorization as provided in paragraph *"a."*

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

(4) Drugs used to promote smoking cessation, except for varenicline with prior authorization as provided in paragraph *"a"* above and generic, sustained-release bupropion products that are indicated for smoking cessation by the U.S. Food and Drug Administration.

(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)).

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

Acetaminophen tablets 325 mg, 500 mg
Acetaminophen elixir 160 mg/5 ml
Acetaminophen solution 100 mg/ml
Acetaminophen suppositories 120 mg
Artificial tears ophthalmic solution
Artificial tears ophthalmic ointment
Aspirin tablets 325 mg, 650 mg, 81 mg (chewable)
Aspirin tablets, enteric coated 325 mg, 650 mg, 81 mg
Aspirin tablets, buffered 325 mg
Bacitracin ointment 500 units/gm
Benzoyl peroxide 5%, gel, lotion
Benzoyl peroxide 10%, gel, lotion
Calcium carbonate chewable tablets 1250 mg (500 mg elemental calcium)
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 patch 7 mg/day, 14 mg/day and 21 mg/day
Pediatric oral electrolyte solutions
Permethrin liquid 1%
Pseudoephedrine hydrochloride tablets 30 mg, 60 mg
Pseudoephedrine hydrochloride liquid 30 mg/5 ml
Pseudoephedrine/dextromethorphan 15 mg/7.5 mg/5 mL liquid
Pseudoephedrine/dextromethorphan 20 mg/10 mg/5 mL liquid
Pseudoephedrine/dextromethorphan 30 mg/15 mg/5 mL liquid
Pseudoephedrine/dextromethorphan 20 mg/10 mg/5 mL elixir
Pseudoephedrine/dextromethorphan 15 mg/7.5 mg/5 mL syrup
Pseudoephedrine/dextromethorphan 30 mg/15 mg/5 mL syrup
Pseudoephedrine/dextromethorphan 7.5 mg/2.5 mg/0.8 mL solution
Pyrethrins-piperonyl butoxide liquid 0.33-4%
Pyrethrins-piperonyl butoxide shampoo 0.3-3%
Pyrethrins-piperonyl butoxide shampoo 0.33-4%
Salicylic acid liquid 17%
Senna tablets 187 mg
Sennosides-docusate sodium tablets 8.6 mg-50 mg
Sennosides syrup 8.8 mg/5 ml
Sennosides tablets 8.6 mg
Sodium bicarbonate tablets 325 mg
Sodium bicarbonate tablets 650 mg
Sodium chloride hypertonic ophthalmic ointment 5%
Sodium chloride hypertonic ophthalmic solution 5%
Tolnaftate 1% cream, solution, powder

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

78.2(6) *Quantity prescribed and dispensed.*

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

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

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

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

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

[**ARC 8097B**, IAB 9/9/09, effective 11/1/09; **ARC 9175B**, IAB 11/3/10, effective 1/1/11]

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 Foundation for Medical Care (IFMC). 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. Readmissions to the same facility due to premature discharge shall

not be paid a new DRG. 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 IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, 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. 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.

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

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

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

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

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

a. Recipient selection and education.

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

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

Intake.

Preparation and waiting period.

Preadmission.

Hospitalization.

Discharge planning.

Follow-up.

b. Staffing and resource commitment.

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

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

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

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

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

The team should consist of:

A surgeon director.

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

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

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

Anesthesiology.

Cardiology.

Dialysis.

Gastroenterology.

Hepatology.

Immunology.

Infectious diseases.

Nephrology.

Neurology.

Pathology.

Pediatrics.

Psychiatry.

Pulmonary medicine.

Radiology.

Rehabilitation medicine.

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

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

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

Anesthesiology.

Blood bank services.

Cardiology.

Cardiovascular surgery.

Dialysis.

Dietary services.

Gastroenterology.

Infection control.

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

Legal counsel familiar with transplantation laws and regulations.

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

Respiratory therapy.

Pharmaceutical services.

Physical therapy.

Psychiatry.

Psycho-social.

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

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

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

c. Experience and survival rates.

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

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

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

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

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

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

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

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

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

Risk and benefit.

Morbidity and mortality.

Long-term survival.

Quality of life.

Recipient demographic information.

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

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

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

Ongoing research regarding the transplanted organs is required.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

78.3(16) 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.

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

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

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

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

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. Payment will also be made for the following dental procedures subject to the exclusions for services to adults 21 years of age and older set forth in subrule 78.4(14):

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 physical or mental disability, 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 in a six-month period except for people who need more frequent applications because of physical or mental disability. (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 disability that impairs their ability to maintain adequate oral hygiene. Replacement sealants are covered when medically necessary, as documented in the patient record.

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

a. A comprehensive oral evaluation is payable once per patient per dentist in a three-year period when the patient has not seen that dentist during the three-year period.

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

c. A complete mouth radiograph survey consisting of a minimum of 14 periapical films and bite-wing films is a payable service once in a five-year period, except when medically necessary to evaluate development, and to detect anomalies, injuries and diseases. Complete mouth radiograph surveys are not payable under the age of six. A panographic-type radiography with bitewings is considered the same as a complete 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 when requested by the Iowa Medicaid enterprise medical services unit's dental consultant.

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. Two laboratory-fabricated crowns using nonprecious materials, other than stainless steel, are payable per member in a 12-month period. Additional laboratory-fabricated crowns using nonprecious materials, other than stainless steel, are payable when prior authorization has been obtained. Noble metals are payable for crowns when members are allergic to all other restorative materials. Stainless steel crowns are payable when a more conservative procedure would not be serviceable. (Cross-reference 78.28(2)*"e"*)

e. Cast post and core, steel post and composite or amalgam in addition to a crown is 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 restorative procedures:

(1) Amalgam or acrylic buildups are considered part of the preparation for the completed restoration.

(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) A two-surface anterior composite restoration will be payable as a one-surface restoration if it involved the lingual surface.

(6) Tooth preparation, temporary restorations, cement bases, pulp capping, impressions, local anesthesia and inhaled 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 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 prophylasix or periodontal services are performed.

b. Periodontal scaling and root planing is payable when prior approval has been received. A request for approval must be accompanied by a plan for treatment, a completed copy of a periodontal probe chart that exhibits pocket depths, history and radiograph(s). Payment for periodontal scaling and root planing will be approved when interproximal and subgingival calculus is evident in X-rays or when justified and documented that curettage, scaling or root planing is required in addition to routine prophylaxis. (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. A request for approval must be accompanied by a plan for treatment, a completed copy of a periodontal probe chart that exhibits pocket depths, history and radiograph(s). 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 patient has demonstrated reasonable oral hygiene, unless the patient is unable to demonstrate reasonable oral hygiene because of physical or mental disability or in cases which demonstrate gingival hyperplasia resulting from drug therapy. (Cross-reference 78.28(2)*"a"*(2))

d. Pedicle soft tissue graft and free soft tissue graft are payable services with prior approval based on a written narrative describing medical necessity. (Cross-reference 78.28(2)*"a"*(3))

e. Periodontal maintenance therapy which includes oral prophylaxis, measurement of pocket depths and limited root planing and scaling is a payable service when prior approval has been received. A request for approval must be accompanied by a periodontal treatment plan, a completed copy of a periodontal probe chart which exhibits pocket depths, periodontal history and radiograph(s). Payment for periodontal maintenance therapy may be approved after periodontal scaling and root planing or periodontal surgical procedures have been provided. Periodontal maintenance therapy may be approved once per three-month interval for moderate to advanced cases if the condition would deteriorate without treatment. (Cross-reference 78.28(2)*"a"*(4))

f. Payment as indicated will be made for the following periodontal services:

(1) Periodontal scaling and root planing, gingivoplasty, osseous surgery will be paid per quadrant.

(2) Gingivoplasty will be paid per tooth.

(3) Osseous allograft will be paid as a single site if one site is involved, or if more than one site is involved, payment will be made for multiple sites.

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 extensive posttreatment restorative procedures are not necessary and when missing teeth do not jeopardize the integrity or function of the dental arches.

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 is payable when prior approval has been received. Payment for 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 will be approved when nonsurgical treatment has been attempted and a reasonable time 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)*"d"*)

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, and failure has been demonstrated with a radiograph and narrative history.

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. General anesthesia, intravenous sedation, and non-intravenous conscious sedation are payable services when the extensiveness of the procedure indicates it or there is a concomitant disease or impairment which warrants its use.

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

k. 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 and a first-time complete denture including six months' postdelivery care. An immediate denture and a first-time complete denture are payable when the denture is provided to establish masticatory function. An immediate denture or a first-time complete denture is payable only once following the removal of teeth it replaces. A complete denture is payable only once in a five-year period except when the denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure and is required to prevent significant dental problems. Replacement of complete dentures due to resorption in less than a five-year period is not payable.

b. A removable partial denture replacing anterior teeth, including six months' postdelivery care. A removable partial denture replacing anterior teeth is payable only once in a five-year period unless the removable partial denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure and is required to prevent significant dental problems. Replacement of a removable partial denture replacing anterior teeth due to resorption in less than a five-year period is not payable.

c. A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. A removable partial denture replacing posterior teeth shall be approved when the member has fewer than eight posterior teeth in occlusion 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. A removable partial denture replacing posterior teeth is payable only once in a five-year period unless the removable partial denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure and is required to prevent significant dental problems. Replacement of a removable partial denture replacing posterior teeth due to resorption in less than a five-year period is not payable. (Cross-reference 78.28(2)*"c"*(1))

d. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth shall be approved for members whose medical condition precludes the use of a removable partial denture. High noble or noble metals shall be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing anterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.28(2)*"c"*(2))

e. A fixed partial denture (including an acid etch fixed partial denture) replacing posterior teeth when prior approval has been received. A fixed partial denture (including an acid etch fixed partial denture) replacing posterior teeth shall be approved for the member whose medical condition precludes the use of a removable partial denture and who has fewer than eight posterior teeth in occlusion or if 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 fixed partial denture brings eight posterior teeth in occlusion, no additional fixed partial denture will be approved. High noble or noble metals will be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing posterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.28(2)*"c"*(3))

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

g. Chairside relines are payable only once per prosthesis every 12 months.

h. Laboratory processed relines are payable only once per prosthesis every 12 months.

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

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

k. 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.

l. 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.

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

a. When prior approval has been given for orthodontic services to treat the most handicapping malocclusions in a manner consistent with "Handicapping Malocclusion Assessment to Establish Treatment Priority," by J.A. Salzmann, D.D.S., American Journal of Orthodontics, October 1968.

A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the patient by causing impaired mastication, dysfunction of

the temporomandibular articulation, susceptibility to periodontal disease, susceptibility to dental caries, and impaired speech due to malpositions of the teeth. Treatment of handicapping malocclusions will be approved only for the severe and the most handicapping. Assessment of the most handicapping malocclusion is determined by the magnitude of the following variables: degree of malalignment, missing teeth, angle classification, overjet and overbite, openbite, and crossbite.

A request to perform an orthodontic procedure must be accompanied by an interpreted cephalometric radiograph and study models trimmed so that the models simulate centric occlusion of the patient. A written plan of treatment must accompany the diagnostic aids. Posttreatment records must be furnished upon request of the Iowa Medicaid enterprise.

Approval may be made for eight units of a three-month active treatment period. Additional units may be approved by the Iowa Medicaid enterprise's orthodontic consultant if found to be medically necessary. (Cross-reference 78.28(2)*"d"*)

b. Space management services shall be payable when there is too little dental ridge to accommodate either the number or the size of teeth and if not corrected significant dental disease will result.

c. Tooth guidance for a limited number of teeth or interceptive orthodontics is a payable service when extensive treatment is not required. Pretreatment records are not required.

78.4(9) *Treatment in a hospital.* Payment will be approved for dental treatment rendered a hospitalized patient only when the mental, physical, or emotional condition of the patient prevents the dentist from providing necessary care in the office.

78.4(10) *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.

78.4(11) *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 exams are not billed for that visit.

78.4(12) *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.

78.4(13) *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 writing prescriptions.

78.4(14) *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.

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 rule 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 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.

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

(1) When 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 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) Protective lenses 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 six years of age.
3. When there is a prescribed 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.

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 once every 12 months for adults aged 21 and over, except for people with a mental or physical disability.

i. Fitting of contact lenses when required following cataract surgery, documented keratoconus, aphakia, or for treatment of acute or chronic eye disease. Up to eight pairs of contact lenses are allowed for children up to one year of age with aphakia. Up to four pairs of contact lenses per year are allowed for children one to three years of age with aphakia.

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, manufactured by reputable American manufacturers.

b. Standard plastic, plastic and metal combination, or metal frames manufactured by reputable American manufacturers, if available.

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.

a. Materials payable by fee schedule are:

(1) 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) Protective lenses and safety frames.

(5) Subnormal visual aids.

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 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.

(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 protective purposes including glasses for eye safety, sunglasses, or glasses with photogray lenses. An exception to this is in 78.6(3)*"b"*(4).

c. A second pair of glasses or spare glasses.

d. Cosmetic surgery and experimental medical and surgical procedures.

e. Contact lenses if vision is correctable with noncontact lenses except as found at paragraph 78.6(1)*"i."*

78.6(6) *Therapeutically certified optometrists.* Therapeutically certified optometrists may provide services and employ pharmaceutical agents in accordance with Iowa Code chapter 154 regulating the practice of optometry. A therapeutically certified optometrist is an optometrist who is licensed to practice optometry in this state and who is certified by the board of optometry to employ the agents and perform the procedures provided by the Iowa Code.

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

[**ARC 7548B**, IAB 2/11/09, effective 4/1/09]

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

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

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

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

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

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

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

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

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

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

c. CMT is not a covered benefit when:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Place of service.

b. Type of service to be rendered and the treatment modalities being used.

c. Frequency of the services.

d. Assistance devices to be used.

e. Date home health services were initiated.

f. Progress of member in response to treatment.

g. Medical supplies to be furnished.

h. Member's medical condition as reflected by the following information, if applicable:

(1) Dates of prior hospitalization.

(2) Dates of prior surgery.

(3) Date last seen by a physician.

(4) Diagnoses and dates of onset of diagnoses for which treatment is being rendered.

(5) Prognosis.

(6) Functional limitations.

(7) Vital signs reading.

(8) Date of last episode of instability.

(9) Date of last episode of acute recurrence of illness or symptoms.

(10) Medications.

i. Discipline of the person providing the service.

j. Certification period (no more than 62 days).

k. Estimated date of discharge from the hospital or home health agency services, if applicable.

l. Physician's signature and date. The plan of care must be signed and dated by the physician before the claim for service is submitted for reimbursement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

78.9(8) *Medical social services.*

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

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

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

(3) Are under the direction of a physician.

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

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

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

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

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

(1) The potential risk factors,

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

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

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

(5) The member's diagnosis,

(6) Specific services and goals, and

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

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

(1) Aged 16 or under.

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

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

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

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

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

(7) Second pregnancy in 12 months.

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

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

(1) Aged 16 or under.

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

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

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

(5) Drug or alcohol abuse.

(6) Symptoms of postpartum psychosis.

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

(8) Demonstrated disturbance in maternal and infant bonding.

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

(10) Insufficient antepartum care by history.

(11) Multiple births.

(12) Nonhospital delivery.

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

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

(2) History of severe respiratory distress.

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

(4) Disabling birth injuries.

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

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

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

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

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

(10) Nutrition or feeding problems.

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

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

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

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

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

(5) Malignancies such as leukemia or carcinoma.

(6) Severe injuries necessitating treatment or rehabilitation.

(7) Disruption in family or peer relationships.

(8) Suspected developmental delay.

(9) Nutritional deficiencies.

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

a. Definitions.

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

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

Private duty nursing or personal care services do not include:

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

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

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

b. Requirements.

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

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

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

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

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

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

78.9(11) *Vaccines.* Home health agencies which 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. Home health agencies may provide Vaccines for Children clinics and be reimbursed for vaccine administration to provide Vaccines for Children program vaccines to Medicaid children in other than the home setting.

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]

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 diagnosis, prognosis, and length of time the item is to be required.

For items requiring prior approval, 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 approval is made on Form 470-0829, Request for Prior Authorization. See rule 441—78.28(249A) for prior approval 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 patient, e.g., elevators, stairway elevators and posture chairs.

e. The amount payable is based on the least expensive item which meets the patient's medical needs. Payment will not be approved for duplicate items.

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 will be maintained on a rental basis for the duration of use.

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.

78.10(2) *Durable medical equipment.* DME is equipment which 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 will not be provided in a hospital, nursing facility, or intermediate care facility for persons with mental retardation. EXCEPTION: Medicaid will provide payment to medical equipment and supply dealers to provide oxygen services in a nursing facility or an intermediate care facility for persons with mental retardation when all of the following requirements and conditions have been met:

(1) A physician's, physician assistant's, or advanced registered nurse practitioner's prescription documents that the member has significant hypoxemia as defined by Medicare and evidenced by supporting medical documentation and the member requires oxygen for 12 hours or more per day for at least 30 days. Oxygen prescribed "PRN" or "as necessary" is not allowed. The documentation maintained in the provider record must contain the following:

1. The number of hours oxygen is required per day;
2. The diagnosis of the disease requiring continuous oxygen, prognosis, and length of time the oxygen will be needed;
3. The oxygen flow rate and concentration; the type of system ordered, i.e., cylinder gas, liquid gas, or concentrator;
4. A specific estimate of the frequency and duration of use; and
5. The initial reading on the time meter clock on each concentrator, where applicable.

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

(3) Medicaid payment shall be made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system, servicing and repairing of equipment are included in the Medicaid payment.

(4) Oxygen logs must be maintained by the provider. When random postpayment review of these logs indicates less than an average of 12 hours per day of oxygen was provided over a 30-day period, recoupment of the overpayment may occur.

(5) Payment will be made for only one mode of oxygen even if the physician's, physician assistant's, or advanced registered nurse practitioner's prescription allows for multiple modes of delivery.

(6) Payment will not be made for oxygen that is not documented according to department of inspections and appeals 481—subrule 58.21(8).

b. Only the following types of durable medical equipment can be covered through the Medicaid program:

Alternating pressure pump.
Automated medication dispenser. See 78.10(2)*"d"* for prior authorization requirements.
Bedpan.
Blood glucose monitors, subject to the limitation in 78.10(2)*"e."*
Blood pressure cuffs.
Cane.
Cardiorespiratory monitor (rental and supplies).
Commode.
Commode pail.
Crutches.
Decubitus equipment.
Dialysis equipment.
Diaphragm (contraceptive device).
Enclosed bed. See 78.10(2)*"d"* for prior authorization requirements.
Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.
Hospital bed.
Hospital bed accessories.
Inhalation equipment.
Insulin infusion pump. See 78.10(2)*"d"* for prior authorization requirements.
Lymphedema pump.
Neuromuscular stimulator.
Oximeter.
Oxygen, subject to the limitations in 78.10(2)*"a"* and 78.10(2)*"c."*
Patient lift (Hoyer).
Phototherapy bilirubin light.
Pressure unit.
Protective helmet.
Respirator.
Resuscitator bags and pressure gauge.
Seat lift chair.
Suction machine.
Traction equipment.
Urinal (portable).
Vaporizer.
Ventilator.
Vest airway clearance system. See 78.10(2)*"d"* for prior authorization requirements.
Walker.
Wheelchair—standard and adaptive.
Whirlpool bath.

c. Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary only for members with significant hypoxemia as defined by Medicare and shown by supporting medical documentation. The physician's, physician assistant's, or advanced registered nurse practitioner's prescription 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 at one year of age and at two years of age and documented in the provider record.

(1) To identify the medical necessity for oxygen therapy, the supplier and a physician, physician assistant, or advanced registered nurse practitioner shall jointly submit Medicare Form B-7401, Physician's Certification for Durable Medical Equipment, or a reasonable facsimile. The following information is required:

1. A diagnosis of the disease requiring home use of oxygen;

2. The oxygen flow rate and concentration;
3. The type of system ordered, i.e., cylinder gas, liquid gas, or concentrator;
4. A specific estimate of the frequency and duration of use; and
5. The initial reading on the time meter clock on each concentrator, where applicable.

Oxygen prescribed "PRN" or "as necessary" is not allowed.

(2) If the patient'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 (doctor of medicine or osteopathy), physician assistant, or advanced registered nurse practitioner of the medical necessity for portable oxygen for specific activities.

(4) Payment for concentrators shall be made only on a rental basis.

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

d. Prior authorization is required for the following medical equipment and supplies (Cross-reference 78.28(1)):

(1) Enclosed beds. Payment for an enclosed bed will be approved when prescribed for a patient who meets all of the following conditions:

1. The patient has a diagnosis-related cognitive or communication impairment that results in risk to safety.
2. The patient's mobility puts the patient at risk for injury.
3. The patient has suffered injuries when getting out of bed.

(2) External insulin infusion pumps. Payment will be approved according to Medicare coverage criteria.

(3) Vest airway clearance systems. Payment will be approved for a vest airway clearance system when prescribed by a pulmonologist for a patient 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 of lung function.
2. The patient 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.

(4) 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 a 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.

(5) Blood glucose monitors and diabetic test strips produced by a manufacturer that does not have a current agreement to provide a rebate to the department for monitors or test strips provided through the Medicaid program. Prior approval shall be granted when the member's medical condition necessitates use of a blood glucose monitor or diabetic test strips produced by a manufacturer that does not have a current rebate agreement with the department.

e. Blood glucose monitors are covered through the Medicaid program only if:

(1) The monitor is produced by a manufacturer that has a current agreement to provide a rebate to the department for monitors provided through the Medicaid program; or

(2) Prior authorization based on medical necessity is received pursuant to rule 441—79.8(249A) for a monitor produced by a manufacturer that does not have a current rebate agreement with the department.

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 patient's condition may improve sometime in the future.

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

b. Only the following types of prosthetic devices shall be covered through the Medicaid program:

(1) Artificial eyes.

(2) Artificial limbs.

(3) Augmentative communications systems provided for members unable to communicate their basic needs through oral speech or manual sign language. Payment will be made for the most cost-effective item that meets basic communication needs commensurate with the member's cognitive and language abilities. See 78.10(3)*"c"* for prior approval requirements.

(4) Enteral delivery supplies and products. See 78.10(3)*"c"* for prior approval requirements.

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

(6) Oral nutritional products. See 78.10(3)*"c"* for prior approval requirements. Nutritional products consumed orally are not covered for members in nursing facilities or intermediate care facilities for the mentally retarded.

(7) Orthotic devices. See 78.10(3)*"d"* for limitations on coverage of cranial orthotic devices.

(8) Ostomy appliances.

(9) 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.

(10) Prosthetic shoes. See rule 441—78.15(249A).

(11) Tracheotomy tubes.

(12) 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. Prior approval is required for the following prosthetic devices:

(1) Augmentative communication systems. Form 470-2145, Augmentative Communication System Selection, completed by a speech pathologist and a physician's, physician assistant's, or advanced registered nurse practitioner's prescription for a particular device shall be submitted to the Iowa Medicaid enterprise medical services unit to request prior approval. Information requested on the prior approval form includes a medical history, diagnosis, and prognosis completed by a physician, physician assistant, or advanced registered nurse practitioner. In addition, a speech or language pathologist needs to describe current functional abilities in the following areas: communication skills, motor status, sensory status, cognitive status, social and emotional status, and language status. Also needed from the speech or language pathologist is information on educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations. The department's consultants with expertise in speech pathology will evaluate the prior approval requests and make recommendations to the department. (Cross-reference 78.28(1)*"c"*)

(2) Enteral products and enteral delivery pumps and supplies. Daily enteral nutrition therapy shall be approved as medically necessary only for a member who either has a metabolic or digestive disorder that prevents the member from obtaining the necessary nutritional value from usual foods in any form and cannot be managed by avoidance of certain food products or has a severe pathology of the body that does not allow ingestion or absorption of sufficient nutrients from regular food to maintain weight and strength commensurate with the member's general condition.

A request for prior approval shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and documentation to establish the medical necessity for enteral products and enteral delivery pumps and supplies pursuant to the above standards. The documentation shall include:

1. A statement of the member's total medical condition that includes a description of the member's metabolic or digestive disorder or pathology.

2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member's nutritional status and indicate that the member's nutritional needs were not or could not be met by regular food in pureed form.

3. Documentation of the medical necessity for an enteral pump, if the request includes an enteral pump. The information submitted must identify the medical reasons for not using a gravity feeding set.

Examples of conditions that will not justify approval of enteral nutrition therapy are: weight-loss diets, wired-shut jaws, diabetic diets, milk or food allergies (unless the member is under five years of age and coverage through the Women, Infant and Children's program is not available), and the use of enteral products for convenience reasons when regular food in pureed form would meet the medical need of the member.

Basis of payment for nutritional therapy supplies shall be the least expensive method of delivery that is reasonable and medically necessary based on the documentation submitted.

(3) Oral nutritional products. Payment for oral nutritional products shall be approved as medically necessary only 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 the mentally retarded. A request for prior approval shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and documentation to establish the medical necessity for oral supplementation pursuant to these standards. The documentation shall include:

1. A statement of the member's total medical condition that includes a description of the member's metabolic, digestive, or psychological disorder or pathology.

2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member's nutritional status and indicate that the member's nutritional needs were not or could not be met by regular food in pureed form.

3. Documentation to support the fact that regular foods will not provide sufficient nutritional value to the member. Examples of conditions that will not justify approval of oral supplementation are: weight-loss diets, wired-shut jaws, diabetic diets, milk or food allergies (unless the member is under five years of age and coverage through the Women, Infant and Children's program is not available), supplementation to boost calorie or protein intake by less than 51 percent of the daily intake, and the absence of severe pathology of the body or psychological pathology or disorder.

d. 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 photographic evidence supporting moderate to severe nonsynostotic positional plagiocephaly and either:

(1) The member is between 3 and 5 months of age and has failed to respond to a two-month trial of repositioning therapy; or

(2) The member is between 6 and 18 months 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. Only the following types of medical supplies and supplies necessary for the effective use of a payable item can be purchased through the medical assistance program:

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 blood glucose test strips, subject to the limitation in 78.10(4)*"c."*

Diabetic supplies, other than blood glucose test strips (needles, syringes, and diabetic urine test supplies).

Dialysis supplies.

Diapers (for members aged four and above).

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

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

Disposable underpads.

Dressings.

Elastic antiembolism support stocking.

Enema.

Hearing aid batteries.

Respirator supplies.

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 the mentally retarded when prescribed by the physician, physician assistant, or advanced registered nurse practitioner:

Catheter (indwelling Foley).

Colostomy and ileostomy appliances.

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

Diabetic supplies (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).

c. Diabetic blood glucose test strips are covered through the Medicaid program only if:

(1) The strips are produced by a manufacturer that has a current agreement to provide a rebate to the department for test strips provided through the Medicaid program, or

(2) Prior authorization is received pursuant to rule 441—79.8(249A) for test strips produced by a manufacturer that does not have a current rebate agreement with the department, based on medical necessity.

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]

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 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) Remedial services. Payment will be made for remedial services not otherwise covered under this chapter that are designed to minimize or, if possible, eliminate the symptoms or causes of a psychological disorder, subject to the limitations in this rule.

78.12(1) *Covered services.* Medicaid covers the following remedial services:

a. Community psychiatric supportive treatment, which offers intensive interventions to modify psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning when less intensive remedial services do not meet the member's needs.

(1) Interventions must focus on the member's remedial needs to minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Interventions may assist the member in skills such as conflict resolution, problem solving, social skills, interpersonal relationship skills, and communication.

(3) Community psychiatric supportive treatment is covered only for Medicaid members who are aged 20 or under.

(4) Community psychiatric supportive treatment is not intended for members in congregate care.

(5) Community psychiatric supportive treatment is not intended to be provided in a group.

b. Crisis intervention 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.

c. Health or behavior intervention, used 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: conflict resolution skills, problem-solving skills, social skills, interpersonal relationship skills, and communication skills.

(2) The purpose of intervention shall be to minimize or eliminate psychological barriers to the member's ability to effectively manage symptoms associated with a psychological disorder in an age-appropriate manner.

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

d. Rehabilitation program, which consists of interventions to enhance a member's independent living, social, and communication skills; to minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and to maximize the member's ability to live and participate in the community.

(1) Interventions may address the following skills for effective functioning with family, peers, and community: communication skills, conflict resolution skills, problem-solving skills, social skills, interpersonal relationship skills, and employment-related skills.

(2) Rehabilitation program services are covered only for Medicaid members who are aged 18 or over.

e. Skills training and development, which consists of interventions to enhance independent living, social, and communication skills; to minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and to maximize a member's ability to live and participate in the community.

(1) Interventions may include the following skills for effective functioning with family, peers, and community: communication skills, conflict resolution skills, problem-solving skills, social skills, interpersonal relationship skills, and employment-related skills.

(2) Skills training and development services are covered only for Medicaid members aged 18 or over.

78.12(2) *Excluded services.* Services that are habilitative in nature are not covered as remedial services. 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.

78.12(3) *Coverage requirements.* Medicaid covers remedial services 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. For example, licensed practitioners of the healing arts include physicians (M.D. or D.O.), advanced registered nurse practitioners (ARNP), psychologists (Ph.D. or Psy.D.), independent social workers (LISW), marital and family therapists (LMFT), and mental health counselors (LMHC). For purposes of this rule, the licensed practitioner of the healing arts must be:

(1) Enrolled in the Iowa Plan pursuant to 441—Chapter 88, Division IV; and

(2) Qualified to provide clinical assessment services under the Iowa Plan pursuant to 441—Chapter 88, Division IV (Current Procedural Terminology code 90801).

b. The licensed practitioner of the healing arts has recommended the remedial services as part of a plan of treatment designed to treat the member's psychological disorder. Diagnosis and treatment plan development provided in connection with this rule for members enrolled in the Iowa Plan are covered services under the Iowa Plan pursuant to 441—Chapter 88, Division IV.

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

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

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

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

d. The remedial services provider has prepared a written remedial services implementation plan that has been approved by:

(1) The member or the member's parent or guardian; and

(2) The medical services unit of the Iowa Medicaid enterprise.

78.12(4) *Approval of plan.* The remedial services provider shall submit the treatment plan, the results of the formal assessment, and the remedial services implementation plan to the Iowa Medicaid enterprise (IME) medical services unit for approval before providing the services.

a. Initial plan. The IME medical services unit shall approve the provider's initial remedial services implementation plan if:

(1) The plan conforms to the medical necessity requirements in subrule 78.12(3);

(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 can demonstrate that the provider possesses the skills and resources necessary to implement the plan, as required in rule 441—77.12(249A);

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

(6) The plan requires that written progress notes be submitted no less often than every six weeks to the IME medical services unit.

b. Subsequent plans. The IME medical services unit may approve a subsequent remedial services implementation plan according to the conditions in paragraph *"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;

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

(4) Submitted the results of the formal assessment with the recommendation for continued services.

c. Quality review. The IME medical services unit will establish a quality review process. Reviews will evaluate:

(1) The time elapsed from referral to remedial plan development;

(2) The continuity of treatment;

(3) The affiliation of the licensed practitioner of the healing arts with the remedial services provider;

(4) Gaps in service;

(5) The results achieved; and

(6) Member satisfaction.

78.12(5) *Medical necessity.* Nothing in this rule shall be deemed to exempt coverage of remedial 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.

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

[**ARC 8504B**, IAB 2/10/10, effective 3/22/10]

441—78.13(249A) Nonemergency medical transportation. Nonemergency transportation to receive medical care, including any reimbursement of transportation expenses incurred by a Medicaid member, shall be provided through the broker designated by the department pursuant to a contract between the department and the broker, as specified in this rule.

78.13(1) *Member request.* When a member needs nonemergency transportation, one way or round trip, to receive medical care provided by the Medicaid program, including any reimbursement of transportation expenses incurred by the member, the member must contact the broker in advance. The broker shall establish and publicize the procedures for members to request transportation services. The broker is required to provide transportation within 72 hours of a request only if receipt of medical care within 72 hours is medically necessary.

78.13(2) *Necessary services.* Transportation shall be provided only when the member needs transportation to receive necessary services covered by the Iowa Medicaid program from an enrolled provider, including transportation needed to obtain prescribed drugs.

78.13(3) *Access to free transportation.* Transportation shall be provided only if the member does not have access to transportation that is available at no cost to the member, such as transportation provided by volunteers, relatives, friends, social service agencies, nursing facilities, residential care centers, or any other source. EXCEPTION: If a prescribed drug is needed immediately, transportation will be provided to obtain the drug even if free delivery is available.

78.13(4) *Closest medical provider.* Transportation beyond 20 miles (one way) shall be provided only to the closest qualified provider unless:

a. The difference between the closest qualified provider and the provider requested by the member is less than 10 miles (one way); or

b. The additional cost of transportation to the provider requested by the member is medically justified based on:

(1) A previous relationship between the member and the requested provider,

(2) Prior experience of the member with closer providers, or

(3) Special expertise or experience of the requested provider.

78.13(5) *Coverage.* Based on the information provided by the member and the provisions of this rule, the broker shall arrange and reimburse for the most economical form of transportation appropriate to the needs of the member.

a. The broker may require that public transportation be used when reasonably available and the member's condition does not preclude its use.

b. The broker may arrange and reimburse for transportation by arranging to reimburse the member for transportation expenses. In that case, the member shall submit transportation expenses to the broker on Form 470-0386, Medical Transportation Claim, or an equivalent electronic form.

c. When a member is unable to travel alone due to age or due to physical or mental incapacity, the broker shall provide for the expenses of an attendant.

d. The broker shall provide for meals, lodging, and other incidental transportation expenses required for the member and for any attendant required due to the age or incapacity of the member in connection with transportation provided under this rule.

78.13(6) *Exceptions for nursing facility residents.*

a. Nonemergency medical transportation for residents of nursing facilities within 30 miles of the nursing facility (one way) shall not be provided through the broker but shall be the responsibility of the nursing facility.

b. Nonemergency medical transportation for residents of nursing facilities beyond 30 miles from the nursing facility (one way) shall be provided through the broker, but the nursing facility shall contact the broker on behalf of the resident.

78.13(7) *Grievances.* Pursuant to its contract with the department, the broker shall establish an internal grievance procedure for members and transportation providers. Members who have exhausted the grievance process may appeal to the department pursuant to 441—Chapter 7 as an "aggrieved person." For transportation providers, the grievance process shall end with binding arbitration, with a designee of the Iowa Medicaid enterprise as arbitrator.

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

[**ARC 8344B**, IAB 12/2/09, effective 12/1/09; **ARC 8643B**, IAB 4/7/10, effective 3/11/10; **ARC 8994B**, IAB 8/11/10, effective 10/1/10]

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) Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as screening center services. Screening centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Screening centers shall receive reimbursement for the administration of vaccines to Medicaid members.

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.

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 recipient'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 a recipient residing in a nursing facility or residential care facility are payable when a statement is submitted signed by the facility 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 recipient residing in an intermediate care facility for the mentally retarded since these facilities are responsible for providing or paying for services required by recipients.

(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.

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.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as rural health center services. Rural health clinics that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. However, the administration of vaccines is a covered service.

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

441—78.22(249A) Family planning clinics. Payments will be made on a fee schedule basis for services provided by family planning clinics.

78.22(1) Payment will be made for sterilization in accordance with 78.1(16).

78.22(2) Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as family planning clinic services. Family planning clinics that wish to administer those vaccines for Medicaid members who receive services at the clinic shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Family planning clinics shall receive reimbursement for the administration of vaccines to Medicaid members.

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

441—78.23(249A) Other clinic services. Payment will be made on a fee schedule basis to facilities not part of a hospital, funded publicly or by private contributions, which provide medically necessary treatment by or under the direct supervision of a physician or dentist to outpatients.

78.23(1) *Sterilization.* Payment will be made for sterilization in accordance with 78.1(16).

78.23(2) *Utilization review.* Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.23(3) *Risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.23(4) *Vaccines.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as clinic services. Clinics that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Clinics shall receive reimbursement for the administration of vaccines to Medicaid members.

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

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).)

Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as maternal health center services. Maternal health centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Maternal health centers shall receive reimbursement for the administration of vaccines to Medicaid members.

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.

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

441—78.26(249A) Ambulatory surgical center services. Ambulatory surgical center services are those services furnished by an ambulatory surgical center in connection with a covered surgical procedure or a covered dental procedure. Covered procedures are listed in the fee schedule published on the department's Web site.

78.26(1) Covered surgical procedures shall be those medically necessary procedures that are eligible for payment as physicians' services, under the circumstances specified in rule 441—78.1(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(2) Covered dental procedures are those medically necessary procedures that are eligible for payment as dentists' services, under the circumstances specified in rule 441—78.4(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting for Medicaid members whose mental, physical, or emotional condition necessitates deep sedation or general anesthesia.

78.26(3) The covered services provided by the ambulatory surgical center in connection with a Medicaid-covered surgical or dental procedure shall be those nonsurgical and nondental services that:

a. Are medically necessary in connection with a Medicaid-covered surgical or dental procedure;

b. Are eligible for payment as physicians' services under the circumstances specified in rule 441—78.1(249A) or as dentists' services under the circumstances specified in rule 441—78.4(249A); and

c. Can safely and economically be performed in an outpatient setting, as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(4) Limits on covered services.

a. Abortion procedures are covered only when criteria in subrule 78.1(17) are met.

b. Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.

c. Preprocedure review by the Iowa Foundation for Medical Care (IFMC) is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth

under subrule 78.1(19). Criteria are available from IFMC, 1776 West Lakes Parkway, West Des Moines, Iowa 50266-8239, or in local hospital utilization review offices. (Cross-reference 78.28(6))

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

[**ARC 8205B**, IAB 10/7/09, effective 11/11/09]

441—78.27(249A) Home- and community-based habilitation services.

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.

"Case management" means case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90.

"Comprehensive service plan" means an individualized, goal-oriented plan of services written in language understandable by the member using the service and developed collaboratively by the member and the case manager.

"Department" means the Iowa department of human services.

"Emergency" means a situation for which no approved individual program plan exists that, if not addressed, may result in injury or harm to the member or to other persons or in significant amounts of property damage.

"HCBS" means home- and community-based services.

"Interdisciplinary team" means a group of persons with varied professional backgrounds who meet with the member to develop a comprehensive service plan to address the member's need for services.

"ISIS" means the department's individualized services information system.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals for qualifying members.

78.27(2) *Member eligibility.* To be eligible to receive home- and community-based habilitation services, a member shall meet the following criteria:

a. Risk factors. The member has at least one of the following risk factors:

(1) The member has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization) more than once in the member's life; or

(2) The member has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.

b. Need for assistance. The member has a need for assistance demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least two years:

(1) The member is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history.

(2) The member requires financial assistance for out-of-hospital maintenance and is unable to procure this assistance without help.

(3) The member shows severe inability to establish or maintain a personal social support system.

(4) The member requires help in basic living skills such as self-care, money management, housekeeping, cooking, and medication management.

(5) The member exhibits inappropriate social behavior that results in a demand for intervention.

c. Income. The countable income used in determining the member's Medicaid eligibility does not exceed 150 percent of the federal poverty level.

d. Needs assessment. The member's case manager has completed an assessment of the member's need for service, and, based on that assessment, the Iowa Medicaid enterprise medical services unit has determined that the member is in need of home- and community-based habilitation services. A member who is not eligible for Medicaid case management services under 441—Chapter 90 shall receive case management as a home- and community-based habilitation service. The designated case manager 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 plan for home- and community-based habilitation services. A service plan that has been validated through ISIS shall be considered approved by the department. Home- and community-based habilitation services provided before department 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 case manager shall apply for services on behalf of a member by entering a program request for habilitation services in ISIS. The department shall issue a notice of decision to the applicant when financial eligibility, determination of needs-based eligibility, and approval of the service plan have been completed.

78.27(4) *Comprehensive service plan.* Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan 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 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 shall establish an interdisciplinary team for the member. The team shall include the case manager 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 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.

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 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 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 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 service 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. Exclusion. Payment shall not be made for case management provided to a member who is eligible for case management services under 441—Chapter 90.

78.27(7) *Home-based habilitation.* "Home-based habilitation" means individually tailored supports that assist with the acquisition, retention, or improvement of skills related to living in the community.

a. Scope. Home-based habilitation services are individualized supportive services provided in the member's home and community that assist the member to reside in the most integrated setting appropriate to the member's needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member shall be determined necessary by the interdisciplinary team and shall be identified in the member's comprehensive service plan. Covered supports include:

(1) Adaptive skill development;
(2) Assistance with activities of daily living;
(3) Community inclusion;
(4) Transportation;
(5) Adult educational supports;
(6) Social and leisure skill development;
(7) Personal care; and
(8) Protective oversight and supervision.

b. Exclusions. Home-based habilitation payment shall not be made for the following:

(1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.

(2) Service activities associated with vocational services, day care, medical services, or case management.

(3) Transportation to and from a day program.

(4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.

(5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or "bundled" service rate, such as a nursing facility or an intermediate care facility for persons with mental retardation.

(6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

78.27(8) *Day habilitation.* "Day habilitation" means assistance with acquisition, retention, or improvement of self-help, socialization, and adaptive skills.

a. Scope. Day habilitation activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services focus on enabling the member to attain or maintain the member's maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the comprehensive service plan. Services may serve to reinforce skills or lessons taught in other settings. Services must enhance or support the member's:

(1) Intellectual functioning;
(2) Physical and emotional health and development;
(3) Language and communication development;
(4) Cognitive functioning;
(5) Socialization and community integration;
(6) Functional skill development;
(7) Behavior management;
(8) Responsibility and self-direction;
(9) Daily living activities;
(10) Self-advocacy skills; or
(11) Mobility.

b. Setting. Day habilitation shall take place in a nonresidential setting separate from the member's residence. Services shall not be provided in the member's home. When the member lives in a residential care facility of more than 16 beds, day habilitation services provided in the facility are not considered to be provided in the member's home if the services are provided in an area apart from the member's sleeping accommodations.

c. Duration. Day habilitation services shall be furnished for four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the member's comprehensive

service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

d. Exclusions. Day habilitation payment shall not be made for the following:

(1) Vocational or prevocational services.

(2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(3) Compensation to members for participating in day habilitation services.

78.27(9) *Prevocational habilitation.* "Prevocational habilitation" means services that prepare a member for paid or unpaid employment.

a. Scope. Prevocational habilitation services include teaching concepts such as compliance, attendance, task completion, problem solving, and safety. Services are not oriented to a specific job task, but instead are aimed at a generalized result. Services shall be reflected in the member's comprehensive service plan and shall be directed to habilitative objectives rather than to explicit employment objectives.

b. Setting. Prevocational habilitation services may be provided in a variety of community-based settings based on the individual need of the member. Meals provided as part of these services shall not constitute a full nutritional regimen (three meals per day).

c. Exclusions. Prevocational habilitation payment shall not be made for the following:

(1) Services that are available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available for the service under these programs shall be maintained in the file of each member receiving prevocational habilitation services.

(2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(3) Compensation to members for participating in prevocational services.

78.27(10) *Supported employment habilitation.* "Supported employment habilitation" means services associated with maintaining competitive paid employment.

a. Scope. Supported employment habilitation services are intensive, ongoing supports that enable members to perform in a regular work setting. Services are provided to members who need support because of their disabilities and who are unlikely to obtain competitive employment at or above the minimum wage absent the provision of supports. Covered services include:

(1) Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a member for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the member and the interdisciplinary team described in subrule 78.27(4) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet a person's employment needs. Second, the member's interdisciplinary team must determine that the identified services are necessary. Third, the Iowa Medicaid enterprise medical services unit must approve the services. Available components of activities to obtain a job are as follows:

1. Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the member holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A member may receive two units of job development services during a 12-month period. The activities provided to the member may include job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities; job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy; and customized job development services specific to the member.

2. Employer development services. The focus of employer development services is to support employers in hiring and retaining members in their workforce and to communicate expectations of the employers to the interdisciplinary team described in subrule 78.27(4). Employer development services

may be provided only to members who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the member holds for 30 consecutive calendar days or more. Payment for this service may be made only after the member holds the job for 30 days. A member may receive two units of employer development services during a 12-month period if the member is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include: developing relationships with employers and providing leads for individual members when appropriate; job analysis for a specific job; development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities; identifying and arranging reasonable accommodations with the employer; providing disability awareness and training to the employer when it is deemed necessary; and providing technical assistance to the employer regarding the training progress as identified on the member's customized training plan.

3. Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided to the member for a minimum of 30 days or with assisting the member in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the member's employment goals. A unit of service is an hour. A maximum of 26 units may be provided in a 12-month period. The services provided may include: job opening identification with the member; assistance with applying for a job, including completion of applications or interviews; and work site assessment and job accommodation evaluation.

(2) Supports to maintain employment, including the following services provided to or on behalf of the member:

1. Individual work-related behavioral management.
2. Job coaching.
3. On-the-job or work-related crisis intervention.
4. Assistance in the use of skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
5. Assistance with time management.
6. Assistance with appropriate grooming.
7. Employment-related supportive contacts.
8. On-site vocational assessment after employment.
9. Employer consultation.

b. Setting. Supported employment may be conducted in a variety of settings, particularly work sites where persons without disabilities are employed.

(1) The majority of coworkers at any employment site with more than two employees where members seek, obtain, or maintain employment must be persons without disabilities.

(2) In the performance of job duties at any site where members seek, obtain, or maintain employment, the member must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(3) When services for maintaining employment are provided to members in a teamwork or "enclave" setting, the team shall include no more than eight people with disabilities.

c. Service requirements. The following requirements shall apply to all supported employment services:

(1) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention.

(2) The provider shall provide employment-related adaptations required to assist the member in the performance of the member's job functions as part of the service.

(3) Community transportation options (such as carpools, coworkers, self or public transportation, families, volunteers) shall be attempted before the service provider provides transportation. When no

other resources are available, employment-related transportation between work and home and to or from activities related to employment may be provided as part of the service.

(4) Members may access both services to maintain employment and services to obtain a job for the purpose of job advancement or job change. A member may receive a maximum of three job placements in a 12-month period and a maximum of 40 units per week of services to maintain employment.

d. Exclusions. Supported employment habilitation payment shall not be made for the following:

(1) Services that are available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available under these programs shall be maintained in the file of each member receiving supported employment services.

(2) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program.

(3) Subsidies or payments that are passed through to users of supported employment programs.

(4) Training that is not directly related to a member's supported employment program.

(5) Services involved in placing or maintaining members in day activity programs, work activity programs, or sheltered workshop programs.

(6) Supports for volunteer work or unpaid internships.

(7) Tuition for education or vocational training.

(8) Individual advocacy that is not member-specific.

78.27(11) *Adverse service actions.*

a. Denial. Services shall be denied when the department determines that:

(1) Rescinded IAB 12/29/10, effective 1/1/11.

(2) The member is not eligible for or in need of home- and community-based habilitation services.

(3) The service is not identified in the member's comprehensive service plan.

(4) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(5) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(6) 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.* The county board of supervisors of the member's county of legal settlement shall reimburse the department for all of the nonfederal share of the cost of home- and community-based habilitation services provided to an adult member with a chronic mental illness as defined in 441—Chapter 90. The department shall notify the county's central point of coordination administrator through ISIS of the approval of the member's service plan.

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]

441—78.28(249A) List of medical services and equipment requiring prior approval, preprocedure review or preadmission review.

78.28(1) Services, procedures, and medications prescribed by a physician (M.D. or D.O.) which are subject to prior approval or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code Supplement 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. (Cross-reference 78.10(2)*"b"*) 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 a 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.

c. Enteral products and enteral delivery pumps and supplies require prior approval. Daily enteral nutrition therapy shall be approved as medically necessary only for a member who either has a metabolic or digestive disorder that prevents the member from obtaining the necessary nutritional value from usual foods in any form and cannot be managed by avoidance of certain food products or has a severe pathology of the body that does not allow ingestion or absorption of sufficient nutrients from regular food to maintain weight and strength commensurate with the member's general condition. (Cross-reference 78.10(3)*"c"*(2))

(1) A request for prior approval shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and documentation to establish the medical necessity for enteral products and enteral delivery pumps and supplies pursuant to the above standards. The documentation shall include:

1. A statement of the member's total medical condition that includes a description of the member's metabolic or digestive disorder or pathology.

2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member's nutritional status and indicate that the member's nutritional needs were not or could not be met by regular food in pureed form.

3. Documentation of the medical necessity for an enteral pump, if the request includes an enteral pump. The information submitted must identify the medical reasons for not using a gravity feeding set.

(2) Examples of conditions that will not justify approval of enteral nutrition therapy are: weight-loss diets, wired-shut jaws, diabetic diets, milk or food allergies (unless the member is under

five years of age and coverage through the Women, Infant and Children's program is not available), and the use of enteral products for convenience reasons when regular food in pureed form would meet the medical need of the member.

(3) Basis of payment for nutritional therapy supplies shall be the least expensive method of delivery that is reasonable and medically necessary based on the documentation submitted.

d. Rescinded IAB 5/11/05, effective 5/1/05.

e. Augmentative communication systems, which are provided to persons unable to communicate their basic needs through oral speech or manual sign language, require prior approval. Form 470-2145, Augmentative Communication System Selection, completed by a speech pathologist and a physician's prescription for a particular device shall be submitted to request prior approval. (Cross-reference 78.10(3)*"c"*(1))

(1) Information requested on the prior authorization form includes a medical history, diagnosis, and prognosis completed by a physician. In addition, a speech or language pathologist needs to describe current functional abilities in the following areas: communication skills, motor status, sensory status, cognitive status, social and emotional status, and language status.

(2) Also needed from the speech or language pathologist is information on educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations.

(3) The department's consultants with an expertise in speech pathology will evaluate the prior approval requests and make recommendations to the department.

f. Preprocedure review by the Iowa Foundation for Medical Care (IFMC) will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and on the published criteria established by the department and the IFMC. If not so approved by the IFMC, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from IFMC, 3737 Woodland Avenue, Suite 500, West Des Moines, Iowa 50265, or in local hospital utilization review offices.

The "Preprocedure Surgical Review List" shall be published by the department in the provider manuals for physicians, hospitals, and ambulatory surgical centers. (Cross-reference 78.1(19))

g. Prior authorization is required for enclosed beds. (Cross-reference 78.10(2)*"c"*) The department shall approve payment for an enclosed bed when prescribed for a patient who meets all of the following conditions:

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

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

(3) The patient has suffered injuries when getting out of bed.

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. Prior authorization is required for oral nutritional products. (Cross-reference 78.10(2)*"c"*) The department shall approve payment for oral nutritional products 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.

(1) A request for prior approval shall include a written order or prescription from a physician, physician assistant, or advanced registered nurse practitioner and documentation to establish the medical necessity for oral nutritional products pursuant to these standards. The documentation shall include:

1. A statement of the member's total medical condition that includes a description of the member's metabolic, digestive, or psychological disorder or pathology.

2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member's nutritional status and indicate that the member's nutritional needs were not or could not be met by regular food in pureed form.

3. Documentation to support the fact that regular foods will not provide sufficient nutritional value to the member, if the request includes oral supplementation of a regular diet.

(2) Examples of conditions that will not justify approval of oral nutritional products are: weight-loss diets, wired-shut jaws, diabetic diets, and milk or food allergies (unless the member is under five years of age and coverage through the Special Supplemental Nutrition Program for Women, Infants, and Children is not available).

j. Prior authorization is required for vest airway clearance systems. (Cross-reference 78.10(2)*"c"*) The department shall approve payment for a vest airway clearance system when prescribed by a pulmonologist for a patient with a medical diagnosis related to a lung disorder if all of the following conditions are met:

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

(2) The patient 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.

k. Prior authorization is required for blood glucose monitors and diabetic test strips produced by a manufacturer that does not have a current agreement to provide a rebate to the department for monitors or test strips provided through the Medicaid program. The department shall approve payment when a blood glucose monitor or diabetic test strips produced by a manufacturer that does not have a current rebate agreement with the department are medically necessary.

78.28(2) Dental services. Dental services which require prior approval are as follows:

a. The following periodontal services:

(1) Payment for periodontal scaling and root planing will be approved when interproximal and subgingival calculus is evident in X-rays or when justified and documented that curettage, scaling or root planing is required in addition to routine prophylaxis. (Cross-reference 78.4(4)*"b"*)

(2) Payment for pedicle soft tissue graft and free soft tissue graft will be approved when the written narrative describes medical necessity. Payment for other periodontal surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the patient has demonstrated reasonable oral hygiene, unless the patient is unable to demonstrate reasonable oral hygiene because of physical or mental disability or in cases which demonstrate gingival hyperplasia resulting from drug therapy. (Cross-reference 78.4(4)*"c"*)

(3) Payment for pedicle soft tissue graft and free soft tissue graft will be approved when the written narrative describes medical necessity. (Cross-reference 78.4(4)*"d"*)

(4) Payment for periodontal maintenance therapy may be approved after periodontal scaling and root planing or periodontal surgical procedures have been provided. Periodontal maintenance therapy may be approved once per three-month interval for moderate to advanced cases if the condition would deteriorate without treatment. (Cross-reference 78.4(4)*"e"*)

b. Surgical endodontic treatment which includes 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 will be approved when nonsurgical treatment has been attempted and a reasonable time 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 78.4(5)*"c"*)

c. The following prosthetic services:

(1) A removable partial denture replacing posterior teeth will be approved when the member has fewer than eight posterior teeth in occlusion 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. A removable partial denture replacing posterior teeth is payable only once in a five-year period unless the removable partial denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure, and is required to prevent significant dental problems. Replacement of a removable partial denture replacing posterior teeth due to resorption in less than a five-year period is not payable. (Cross-reference 78.4(7)*"c"*)

(2) A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth will be approved for members whose medical condition precludes the use of a removable partial denture. High noble or noble metals will be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing anterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.4(7)*"d"*)

(3) A fixed partial denture (including an acid etch fixed partial denture) replacing posterior teeth will be approved for members whose medical condition precludes the use of a removable partial denture and who have fewer than eight posterior teeth in occlusion or if 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 fixed partial denture brings eight posterior teeth in occlusion, no additional fixed partial denture will be approved. High noble or noble metals will be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing posterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.4(7)*"e"*)

(4) Dental implants and related services will be authorized 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.

d. Orthodontic services will be approved when it is determined that a patient has the most handicapping malocclusion. This determination is made in a manner consistent with the "Handicapping Malocclusion Assessment to Establish Treatment Priority," by J. A. Salzmann, D.D.S., American Journal of Orthodontics, October 1968.

(1) A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the patient by causing impaired mastication, dysfunction of the temporomandibular articulation, susceptibility to periodontal disease, susceptibility to dental caries, and impaired speech due to malpositions of the teeth. Treatment of handicapping malocclusions will be approved only for the severe and the most handicapping. Assessment of the most handicapping malocclusion is determined by the magnitude of the following variables:

1. Degree of malalignment;
2. Missing teeth;
3. Angle classification;
4. Overjet and overbite;
5. Openbite; and
6. Crossbite.

(2) A request to perform an orthodontic procedure must be accompanied by an interpreted cephalometric radiograph and study models trimmed so that the models simulate centric occlusion of the patient. A written plan of treatment must accompany the diagnostic aids. Posttreatment records must be furnished upon request of the Iowa Medicaid enterprise medical services unit.

(3) Approval may be made for eight units of a three-month active treatment period. Additional units may be approved by the department's orthodontic consultant if the additional units are found to be medically necessary. (Cross-reference 78.4(8)*"a"*)

e. More than two laboratory-fabricated crowns will be approved in a 12-month period for anterior teeth that cannot be restored with a composite or amalgam restoration and for posterior teeth that

cannot be restored with a composite or amalgam restoration or stainless steel crown. (Cross-reference 78.4(3)*"d"*)

f. Endodontic retreatment of a tooth will be authorized when the conventional treatment has been completed, a reasonable time has elapsed, and failure has been demonstrated with a radiograph and narrative history.

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.

For all of the above, the optometrist shall furnish sufficient information to clearly establish that these procedures are necessary in terms of the visual condition of the patient. (Cross-references 78.6(4), 441—78.7(249A), and 78.1(18))

78.28(4) Hearing aids that must be submitted for prior approval are:

a. Replacement of a hearing aid less than four years old (except when the member is under 21 years of age). The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person's hearing that would require a different hearing aid. (Cross-reference 78.14(7)*"d"*(1))

b. A hearing aid costing more than $650. The department shall approve payment for either of the following purposes (Cross-reference 78.14(7)*"d"*(2)):

(1) Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

(2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

78.28(5) Hospital services which must be subject to prior approval, preprocedure review or preadmission review are:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the hospital as long as the approval is obtained by the physician. (Cross-reference 441—78.1(249A))

b. All inpatient hospital admissions are subject to preadmission review. Payment for inpatient hospital admissions is approved when it meets the criteria for inpatient hospital care as determined by the IFMC or its delegated hospitals. Criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. (Cross-reference 441—78.3(249A))

c. Preprocedure review by the IFMC is required if hospitals are to be reimbursed for the inpatient and outpatient surgical procedures set forth in subrule 78.1(19). Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and the criteria

established by the department and IFMC. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

78.28(6) Ambulatory surgical centers are subject to prior approval and preprocedure review as follows:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the ambulatory surgical center as long as the prior approval is obtained by the physician.

b. Preprocedure review by the IFMC is required if ambulatory surgical centers are to be reimbursed for surgical procedures as set forth in subrule 78.1(19). Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and criteria established by the IFMC and the department. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

78.28(7) Rescinded IAB 6/4/08, effective 5/15/08.

78.28(8) Rescinded IAB 1/3/96, effective 3/1/96.

78.28(9) Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

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

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member.

Private duty nursing services do not include:

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

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

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

b. Requirements.

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

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

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

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

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross-reference 78.9(10))

78.28(10) Replacement of vibrotactile aids less than four years old shall be approved when the original aid is broken beyond repair or lost. (Cross-reference 78.10(3)*"b"*)

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]

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, or master social worker 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.

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.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as birth center services. Birth centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Birth centers shall receive reimbursement for the administration of vaccines to Medicaid members.

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

441—78.31(249A) Hospital outpatient services.

78.31(1) *Covered hospital outpatient services.* Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital or pursuant to subrule 78.31(5). Hospitals with alternate sites approved by the department of inspections and appeals are acceptable sites. All outpatient services listed in paragraphs *"g"* to *"m"* are subject to a random sample retrospective review for medical necessity by the Iowa Foundation for Medical Care. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs *"a"* to *"f"* shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs *"g"* to *"m"* shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

a. Emergency service.
b. Outpatient surgery.
c. Laboratory, X-ray and other diagnostic services.
d. General or family medicine.
e. Follow-up or after-care specialty clinics.
f. Physical medicine and rehabilitation.
g. Alcoholism and substance abuse.
h. Eating disorders.
i. Cardiac rehabilitation.
j. Mental health.
k. Pain management.
l. Diabetic education.
m. Pulmonary rehabilitation.
n. Nutritional counseling for persons aged 20 and under.

78.31(2) *Requirements for all outpatient services.*

a. Need for service. It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

b. Professional direction. All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

c. Goals and objectives. The goals and objectives of the program must be clearly stated. Paragraphs *"d"* and *"f"* and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

d. Treatment modalities used. The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

e. Criteria for selection and continuing treatment of patients. The condition or disease which is proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

f. Length of program. There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

g. Monitoring of services. The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

h. Hospital outpatient programs 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. Hospital outpatient programs receive payment via the APC reimbursement for the administration of vaccines to Medicaid members.

78.31(3) *Application for certification.* Hospital outpatient programs listed in subrule 78.31(1), paragraphs *"g"* to *"m,"* must submit an application to the Iowa Medicaid enterprise provider services unit for certification before payment will be made. The provider services unit will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

a. Documented need for the program including studies, needs assessments, and consultations with other health care professionals.

b. Goals and objectives of the program.

c. Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff's relationship to the program, e.g., hospital employee, contractual consultant.

d. Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.

e. Any accreditations or other types of approvals from national or state organizations.

f. The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

78.31(4) *Requirements for specific types of service.*

a. Alcoholism and substance abuse.

(1) Approval by joint commission or substance abuse commission. In addition to certification by the department, alcoholism and substance abuse programs must also be approved by either the joint commission on the accreditation of hospitals or the Iowa substance abuse commission.

(2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient's dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, gender, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups, including but not limited to, learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

(3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance abuse counselor certified by the Iowa board of substance abuse certification. Psychiatric consultation must be available and the number of staff should be appropriate to the patient load of the facility.

(4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted which shall include:

A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.

A comprehensive medical history and physical examination including the history of physical problems associated with dependence.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

Any history of physical abuse.

A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of alcoholism and other drug dependencies.

The patient's educational level, vocational status, and job performance history.

The patient's social support networks, including family and peer relationships.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and in programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission.

Legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

Alcohol or drugs taken in greater amounts over a longer period than the person intended.

Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.

Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.

Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.

Characteristic withdrawal symptoms.

Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

(6) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level.

If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

b. Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa, bulimia, or bulimarexia. Compulsive overeaters are not acceptable for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master's or bachelor's degree and experience, a dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient's eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

A history of exercise behavior, including type, frequency, and duration.

A complete history of current alcohol and other drug use.

Any suicidal thoughts or attempts.

Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.

History of experiencing physical or sexual (incest or rape) abuse.

History of other counseling experiences.

Appropriate psychological assessment, including psychological orientation to the above questions.

A medical history, including a physical examination, covering the information listed in subparagraph (4) below.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

The patient's social support networks, including family and peer relationships.

The patient's educational level, vocational status, and job or school performance history, as appropriate.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission as appropriate.

Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia as established by the DSM III R (Diagnostic and Statistical Manual, Third Edition, Revised).

In addition to the diagnostic criteria, the need for treatment will be determined by a demonstrable loss of control of eating behaviors and the failure of the patient in recent attempts at voluntary self-control of the problem. Demonstrable impairment, dysfunction, disruption or harm of physical health, emotional health (e.g., significant depression withdrawal, isolation, suicidal ideas), vocational or educational functioning, or interpersonal functioning (e.g., loss of relationships, legal difficulties) shall have occurred.

The need for treatment may be further substantiated by substance abuse, out-of-control spending, incidence of stealing to support habit, or compulsive gambling.

The symptoms shall have been present for at least six months and three of the following criteria must be present:

Medical criteria including endocrine and metabolic factors (e.g., amenorrhea, menstrual irregularities, decreased reflexes, cold intolerance, hypercarotenemia, parotid gland enlargement, lower respiration rate, hair loss, abnormal cholesterol or triglyceride levels).

Other cardiovascular factors including hypotension, hypertension, arrhythmia, ipecac poisoning, fainting, or bradycardia.

Renal considerations including diuretic abuse, dehydration, elevated BUN, renal calculi, edema, or hypokalemia.

Gastrointestinal factors including sore throats, 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.

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 on a monthly payment per enrollee basis will be approved for the case management functions required in 441—Chapter 90.

78.33(1) Payment will be approved for MR/CMI/DD case management services pursuant to 441—Chapter 90 to:

a. Recipients 18 years of age or over with a primary diagnosis of mental retardation, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).

b. Rescinded IAB 1/8/03, effective 1/1/03.

c. Recipients under 18 years of age receiving HCBS MR waiver or HCBS children's mental health waiver services.

78.33(2) Payment for services pursuant to 441—Chapter 90 to recipients under age 18 who have a primary diagnosis of mental retardation or developmental disabilities as defined in rule 441—90.1(249A) and are residing in a child welfare decategorization county shall be made when the following conditions are met:

a. The child welfare decategorization county has entered into an agreement with the department certifying that the state match for case management is available within funds allocated for the purpose of decategorization.

b. The child welfare decategorization county has executed an agreement to remit the nonfederal share of the cost of case management services to the enhanced mental health, mental retardation and developmental disabilities services fund administered by the department.

c. The child welfare decategorization county has certified that the funds remitted for the nonfederal share of the cost of case management services are not federal funds.

78.33(3) Rescinded IAB 10/12/05, effective 10/1/05.

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

441—78.34(249A) HCBS ill and handicapped waiver services. Payment will be approved for the following services to clients eligible for HCBS ill and handicapped waiver services as established in 441—Chapter 83. Services must be billed in whole units.

78.34(1) *Homemaker services.* Homemaker services are those services provided when the client lives alone or when the person who usually performs these functions for the client needs assistance with performing the functions. A unit of service is one hour. Components of the service are directly related to the care of the client and include:

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 client, and dishes.

c. Rescinded IAB 9/30/92, effective 12/1/92.

d. 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 a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). Components of the service are as set forth in rule 441—171.6(234) or the department of elder affairs rule 321—24.7(231).

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 consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer'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. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

e. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite, or group respite as defined in rule 441—83.1(249A).

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.

78.34(6) *Counseling services.* Counseling services are face-to-face mental health services provided to the client and caregiver by a mental health professional as defined in rule 441—24.61(225C,230A) to facilitate home management of the client 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 client's family or other caregiver to provide care, and for the purpose of helping the client and those caring for the client to adjust to the client's disability or terminal condition. Counseling services may be provided to the client's caregiver only when included in the case plan for the client.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver client or the waiver client and the client's caregiver is 15 minutes. A unit of group counseling is one hour. 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 consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.

(1) Tube feedings of consumers 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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes 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.

c. A unit of service is 1 hour, or one 8- to 24-hour day provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer'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.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.34(8) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. The services must be needed to allow the consumer's usual caregivers to be employed or, for a limited period of time, for academic or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver.

a. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each consumer's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a consumer with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.

b. Interim medical monitoring and treatment services may include supervision to and from school.

c. Limitations.

(1) A maximum of 12 one-hour units 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.

(4) Interim medical monitoring and treatment services may be provided only in the consumer's home, in a registered group child care home, in a registered family child care home, in a licensed child care center, or during transportation to and from school.

(5) The staff-to-consumer ratio shall not be less than one to six.

d. A unit of service is one hour.

78.34(9) *Home and vehicle modifications.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer'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, roof repair, or adding square footage to the residence, are excluded except as specifically included below. 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 consumer'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 department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications. Payment of up to $6,060 per year may be made to certified providers upon satisfactory completion of the service. The service worker shall encumber up to $505 per month within the monthly dollar cap allowed for the consumer until the amount of the modification is reached within the 12-month period.

h. Services shall be included in the consumer's service plan and shall exceed the Medicaid state plan services.

78.34(10) *Personal emergency response system.* 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 when the consumer is alone.

a. The required components of the system are:

(1) An in-home medical communications transmitter and receiver.

(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 consumer.

b. The service shall be identified in the consumer's service plan.

c. A unit of service is a one-time installation fee or one month of service.

d. Maximum units per state fiscal year shall be the initial installation and 12 months of service.

78.34(11) *Home-delivered meals.* Home-delivered meals means meals prepared elsewhere and delivered to a waiver recipient at the recipient's residence. Each meal shall ensure the recipient 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. When a restaurant provides the home-delivered meal, the recipient is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the client and what constitutes the minimum one-third daily dietary allowance.

A maximum of 14 meals is allowed per week. 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 ill and handicapped 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).

(3) Schedule the provision of services.

(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.

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

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10]

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 consumers eligible for the HCBS elderly waiver services as established in 441—Chapter 83. The consumer shall have a billable waiver service each calendar quarter. Services must be billed in whole units.

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 a half day (1 to 4 hours), a

full day (4 to 8 hours), or an extended day (8 to 12 hours). Components of the service are set forth in rule 441—171.6(234) or as indicated in the Iowa department of elder affairs Annual Service and Fiscal Reporting Manual.

78.37(2) *Emergency response system.* The emergency response system allows a person experiencing a medical emergency at home to activate electronic components that transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The necessary components of a system are:

a. An in-home medical communications transceiver.

b. A remote, portable activator.

c. A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days per week.

d. Current data files at the central monitoring station containing preestablished response protocols and personal, medical, and emergency information for each client.

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 client lives alone or when the person who usually performs these functions for the client is incapacitated or occupied providing direct care to the client. A unit of service is one hour. Components of the service include:

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, and washing and mending clothes.

c. Accompaniment to medical or psychiatric services.

d. Meal preparation: planning and preparing balanced meals.

e. Bathing and dressing for self-directing recipients.

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 consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer'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. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.21(249A).

e. When respite care is provided, the provision of, or payment for, other duplicative services under the waiver is precluded.

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 care is not to be provided to persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

78.37(7) *Chore services.* Chore services include the following services: window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows; minor repairs to walls, floors, stairs, railings and handles; heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care or painting and trash removal; and yard work such as mowing lawns, raking leaves and shoveling walks. A unit of service is one-half hour.

78.37(8) *Home-delivered meals.* Home-delivered meals means meals prepared elsewhere and delivered to a waiver recipient at the recipient's residence. Each meal shall ensure the recipient 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. When a restaurant provides the home-delivered meal, the recipient is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the client and explain what constitutes the minimum one-third daily dietary allowance.

A maximum of 14 meals is allowed per week. A unit of service is a meal.

78.37(9) *Home and vehicle modification.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer'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, roof repair, or adding square footage to the residence, are excluded except as specifically included below. 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 consumer'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 department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the consumer'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 recipients to conduct business errands, essential shopping, to receive medical services not reimbursed through medical transportation, and to reduce social isolation. A unit of service is per mile, per trip, or rate established by area agency on aging.

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.

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 one hour.

78.37(15) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.

(1) Tube feedings of consumers 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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes 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.

c. A unit of service provided by an individual or an agency, other than an assisted living program, is 1 hour, or one 8- to 24-hour day. When provided by an assisted living program, a unit of service is one calendar month. If services are provided by an assisted living program for less than one full calendar month, the monthly reimbursement rate shall be prorated based on the number of days service is provided. Except for services provided by an assisted living program, each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer'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.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

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).

(3) Schedule the provision of services.

(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.

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]

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to clients eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83. Services must be billed in whole units.

78.38(1) *Counseling services.* Counseling services are face-to-face mental health services provided to the client and caregiver by a mental health professional as defined in rule 441—24.61(225C,230A) to facilitate home management of the client 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 client's family or other caregiver to provide care, and for the purpose of helping the client and those caring for the client to adjust to the client's disability or terminal condition. Counseling services may be provided to the client's caregiver only when included in the case plan for the client.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver client or the waiver client and the client's caregiver is 15 minutes. A unit of group counseling is one hour. 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 client lives alone or when the person who usually performs these functions for the client needs assistance with performing the functions. A unit of service is one hour. Components of the service are directly related to the care of the client and are:

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 client, and dishes.

c. Accompaniment to medical or psychiatric services or for children aged 18 and under to school.

d. 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 consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer's home shall not be reimbursable if the living unit where respite is provided is otherwise reserved for another person on a temporary leave of absence.

b. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.41(249A).

e. When respite care is provided, the provision of, or payment for, other duplicative services under the waiver is precluded.

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 care is not to be provided to persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

78.38(6) *Home-delivered meals.* Home-delivered meals means meals prepared elsewhere and delivered to a waiver recipient at the recipient's residence. Each meal shall ensure the recipient 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. A maximum of 14 meals is allowed per week. 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 a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). Components of the service are as set forth in rule 441—171.6(234) or the department of elder affairs rule 321—24.7(231).

78.38(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.

(1) Tube feedings of consumers 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, reteaching the activities of daily

living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes 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.

c. A unit of service is 1 hour, or one 8- to 24-hour day provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer'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.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

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).

(3) Schedule the provision of services.

(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.

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

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10]

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.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered services. Federally qualified health centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. However, vaccine administration is a covered service.

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

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) *Vaccine administration.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered services. Advanced registered nurse practitioners who wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Advanced registered nurse practitioners shall receive reimbursement for the administration of vaccines to Medicaid members.

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.

441—78.41(249A) HCBS MR waiver services. Payment will be approved for the following services to consumers eligible for the HCBS MR waiver services as established in 441—Chapter 83 and as identified in the consumer's service plan. All services include the applicable and necessary instruction, supervision, assistance and support as required by the consumer in achieving the consumer's life goals. The services, amount and supports provided under the HCBS MR waiver shall be delivered in the least restrictive environment and in conformity with the consumer's service plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through the Medicaid state plan.

All services shall be billed in whole units.

78.41(1) *Supported community living services.* Supported community living services are provided by the provider within the consumer's home and community, according to the individualized consumer need as identified in the service plan pursuant to rule 441—83.67(249A).

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 those activities which assist a consumer to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) "Individual advocacy services" means the act or process of representing the individual's rights and interests in order to realize the rights to which the individual is entitled and to remove barriers to meeting the individual's needs.

(3) "Community skills training services" means activities which assist a person to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they are applicable to individuals being served:

1. Personal management skills training services are activities which assist a person to maintain or develop skills necessary to sustain oneself in the physical environment and are essential to the management of one'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; ability to use community resources such as public transportation, libraries, etc., and ability to select foods at the grocery store.

2. Socialization skills training services are those activities which assist a consumer 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 person 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" means activities and expenditures provided to or on behalf of a person in the areas of personal needs in order to allow the person to function in the least restrictive environment.

(5) "Transportation services" means activities and expenditures designed to assist the person to travel from one place to another to obtain services or carry out life's activities. The service excludes transportation to and from work.

(6) "Treatment services" means activities designed to assist the person to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to a person's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment means activities including medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. The activities shall be provided by or under the supervision of a health care professional certified or licensed to provide the treatment activity specified.

2. Psychotherapeutic treatment means activities provided to assist a person in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the person'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 consumer 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 consumers 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 time periods when another resource is not available.

(2) Supported community living services shall be available at an hourly rate to consumers for whom a daily rate is not established.

c. Services may be provided to a child or an adult. A maximum of three consumers receiving community-supported alternative living arrangements or HCBS MR services may reside in a living unit except providers meeting requirements set forth in 441—paragraph 77.37(14)*"e."*

(1) Consumers may live within the home of their family or legal representative or within other types of typical community living arrangements.

(2) Consumers of services living with families or legal representatives are not subject to the maximum of three consumers in a living unit.

(3) Consumers may not live in licensed medical or health care facilities or in settings required to be licensed as medical or health care facilities.

(4) Consumers aged 17 or under living within the home of their family, legal representative, or foster families 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.

d. Rescinded IAB 2/5/03, effective 2/1/03.

e. Transportation to and from a day program is not a reimbursable service. Maintenance and room and board costs are not reimbursable.

f. Provider budgets shall reflect all staff-to-consumer ratios and shall reflect costs associated with consumers' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed $1570 per consumer per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a consumer residing in the living unit receives on-site staff supervision for 14 or more hours per day as an average over a 7-day week and the consumer's individual comprehensive plan or case plan identifies and reflects the need for this amount of supervision.

(2) One hour when subparagraph (1) does not apply.

g. The maximum number of units available per consumer is as follows:

(1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.

(2) 5,110 hourly units are available per state fiscal year except a leap year when 5,124 hourly units are available.

h. The service shall be identified in the consumer's individual comprehensive plan.

i. Services shall not be simultaneously reimbursed with other residential services, HCBS MR respite, Medicaid or HCBS MR nursing, or Medicaid or HCBS MR home health aide services.

78.41(2) *Respite services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer's home shall not be reimbursable if the living unit where the respite is provided is reserved for another person on a temporary leave of absence.

b. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. Payment for respite services shall not exceed $7,050 per the consumer's waiver year.

e. The service shall be identified in the consumer's individual comprehensive plan.

f. Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS MR waiver supported community living services, Medicaid or HCBS MR nursing, or Medicaid or HCBS MR home health aide services.

g. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

h. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.60(249A).

i. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

j. 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.

78.41(3) *Personal emergency response system.* The personal emergency response system is an electronic component that transmits a coded signal via digital equipment to a central monitoring station. The electronic device allows a person to access assistance in the event of an emergency when alone.

a. 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 24 hours per day, seven days per week.

(4) Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each consumer.

b. The service shall be identified in the consumer's individual comprehensive plan.

c. A unit is a one-time installation fee or one month of service.

d. Maximum units per state fiscal year are the initial installation and 12 months of service.

78.41(4) *Home and vehicle modifications.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer'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, roof repair, or adding square footage to the residence, are excluded except as specifically included below. 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 consumer'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 department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the consumer'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 consumer 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 MR 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 consumer's individual comprehensive plan.

b. A unit is one hour.

c. A maximum of 14 units are available per week.

78.41(7) *Supported employment services.* Supported employment services are individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs *"a"* and *"b"* that address the disability-related challenges to securing and keeping a job.

a. Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a consumer for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the consumer and the interdisciplinary team described in 441—subrule 83.67(1) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet a person's employment needs. Second, the consumer's interdisciplinary team must determine that the identified services are necessary. Third, the consumer's case manager must approve the services. Available components of activities to obtain a job are as follows:

(1) Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the consumer holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A consumer may receive two units of job development services during a 12-month period. The activities provided to the consumer may include:

1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.

2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.

3. Customized job development services specific to the consumer.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining consumers in their workforce and to communicate expectations of the employers to the interdisciplinary team described in 441—subrule 83.67(1). Employer development services may be provided only to consumers who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the consumer holds for 30 consecutive calendar days or more. Payment for this service may be made only after the consumer holds the job for 30 days. A consumer may receive two units of employer development services during a 12-month period if the consumer is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:

1. Developing relationships with employers and providing leads for individual consumers when appropriate.

2. Job analysis for a specific job.

3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.

4. Identifying and arranging reasonable accommodations with the employer.

5. Providing disability awareness and training to the employer when it is deemed necessary.

6. Providing technical assistance to the employer regarding the training progress as identified on the consumer's customized training plan.

(3) Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided for a minimum of 30 days or with assisting the consumer in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the consumer's

employment goals. A unit of service is an hour. A maximum of 26 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the consumer.
2. Assistance with applying for a job, including completion of applications or interviews.
3. Work site assessment and job accommodation evaluation.

b. Supports to maintain employment.

(1) Covered services provided to or on behalf of the consumer associated with maintaining competitive paid employment are the following:

1. Individual work-related behavioral management.
2. Job coaching.
3. On-the-job or work-related crisis intervention.
4. Assisting the consumer to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
5. Consumer-directed attendant care services as defined in subrule 78.41(8).
6. Assistance with time management.
7. Assistance with appropriate grooming.
8. Employment-related supportive contacts.
9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.
10. On-site vocational assessment after employment.
11. Employer consultation.

(2) Services for maintaining employment may include services associated with sustaining consumers in a team of no more than eight individuals with disabilities in a teamwork or "enclave" setting.

(3) A unit of service is one hour.

(4) A maximum of 40 units may be received per week.

c. The following requirements apply to all supported employment services:

(1) Employment-related adaptations required to assist the consumer within the performance of the consumer's job functions shall be provided by the provider as part of the services.

(2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.

(3) The majority of coworkers at any employment site with more than two employees where consumers seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where consumers seek, obtain, or maintain employment, the consumer must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.

(5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each consumer.

(6) All services shall be identified in the consumer's service plan maintained pursuant to rule 441—83.67(249A).

(7) The following services are not covered:

1. Services involved in placing or maintaining consumers in day activity programs, work activity programs or sheltered workshop programs;
2. Supports for volunteer work or unpaid internships;

3. Tuition for education or vocational training; or

4. Individual advocacy that is not consumer specific.

(8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

78.41(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.

(1) Tube feedings of consumers 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, reteaching the activities of daily

living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes 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.

c. A unit of service is 1 hour, or one 8- to 24-hour day provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker or case manager prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer'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.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.41(9) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. The services must be needed to allow the consumer's usual caregivers to be employed or, for a limited period of time, for academic or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver.

a. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each consumer's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a consumer with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.

b. Interim medical monitoring and treatment services may include supervision to and from school.

c. Limitations.

(1) A maximum of 12 one-hour units 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.

(4) Interim medical monitoring and treatment services may be provided only in the consumer's home, in a registered group child care home, in a registered family child care home, in a licensed child care center, or during transportation to and from school.

(5) The staff-to-consumer ratio shall not be less than one to six.

d. A unit of service is one hour.

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 consumers to conduct business errands and essential shopping, to receive medical services when not reimbursed through medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging. Transportation may not be reimbursed simultaneously with HCBS MR waiver supported community living service.

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. A unit of service is a full day (4 to 8 hours) or a half-day (1 to 4 hours) or an extended day (8 to 12 hours).

78.41(13) *Prevocational services.* Prevocational services are services that are aimed at preparing a consumer eligible for the HCBS MR waiver for paid or unpaid employment, but are not job-task oriented. These services include teaching the consumer concepts necessary as job readiness skills, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

a. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities that are not primarily directed at teaching specific job skills but at more generalized habilitative goals, and are reflected in a habilitative plan that focuses on general habilitative rather than specific employment objectives.

b. Prevocational services do not include:

(1) Services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) that are otherwise available to the consumer through a state or local education agency.

(2) Vocational rehabilitation services that are otherwise available to the consumer through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

78.41(14) *Day habilitation services.*

a. Scope. Day habilitation services are services that assist or support the consumer in developing or maintaining life skills and community integration. Services must enable or enhance the consumer'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 consumer's home. The unit of service is an hour. The units of services payable are limited to a maximum of 10 hours per month.

c. Unit of service. Except as provided in paragraph *"b,"* the unit of service may be an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

d. Exclusions.

(1) Services shall not be provided in the consumer's home, except as provided in paragraph *"b."* For this purpose, services provided in a residential care facility where the consumer lives are not considered to be provided in the consumer'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).

(3) Schedule the provision of services.

(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.

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

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10]

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 program administered by the department of public health if the pharmacy is enrolled in the vaccines for children program. No payment will be made for the vaccine.

[**ARC 9132B**, IAB 10/6/10, effective 11/1/10; **ARC 9316B**, IAB 12/29/10, effective 2/2/11]

441—78.43(249A) HCBS brain injury waiver services. Payment shall be approved for the following services to consumers eligible for the HCBS brain injury services as established in 441—Chapter 83 and as identified in the consumer's service plan. All services shall include the applicable and necessary instructions, supervision, assistance and support as required by the consumer in achieving the goals written specifically in the service plan. The services, amount and supports provided under the HCBS brain injury waiver shall be delivered in the least restrictive environment and in conformity with the consumer's service plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through regular Medicaid.

All services shall be billed in whole units.

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 at the ICF/MR level of care whose county has voluntarily chosen to participate in the HCBS brain injury waiver are eligible for targeted case management and, therefore, 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 consumer's home and community, according to the individualized consumer need as identified in the individual comprehensive plan (ICP) or department case plan. Intermittent service shall be provided as defined in rule 441—83.81(249A).

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 those activities which assist a consumer 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 individual's rights and interests in order to realize the rights to which the individual is entitled and to remove barriers to meeting the individual's needs.

(3) Community skills training services are those activities which assist a person to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they are applicable to individuals being served:

1. Personal management skills training services are activities which assist a person to maintain or develop skills necessary to sustain oneself in the physical environment and are essential to the management of one'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 those activities which assist a consumer 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 person 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 person in the areas of personal needs in order to allow the person to function in the least restrictive environment.

(5) Transportation services are those activities and expenditures designed to assist the consumer to travel from one place to another to obtain services or carry out life's activities. The service excludes transportation to and from work or day programs.

(6) Treatment services are those activities designed to assist the person to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to a person's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

Physiological treatment means activities including medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the

human body. The activities shall be provided by or under the supervision of a health care professional certified or licensed to provide the treatment activity specified.

Psychotherapeutic treatment means activities provided to assist a person in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the person'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 consumer 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 consumers 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 time periods when another resource is not available.

(2) Supported community living services shall be available at an hourly rate to consumers for whom a daily rate is not established.

(3) Intermittent service shall be provided as defined in rule 441—83.81(249A).

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 three consumers may reside in a living unit, except when the provider meets the requirements set forth in 441—paragraph 77.39(13)*"e."*

(1) Consumers may live in the home of their family or legal representative or in other types of typical community living arrangements.

(2) Consumers of services living with families or legal representatives are not subject to the maximum of three consumers in a living unit.

(3) Consumers may not live in licensed medical or health care facilities or in settings required to be licensed as medical or health care facilities.

(4) Consumers aged 17 or under living in the home of their family, legal representative, or foster families 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.

d. Rescinded IAB 2/5/03, effective 2/1/03.

e. Provider budgets shall reflect all staff-to-consumer ratios and shall reflect costs associated with consumers' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed $1570 per consumer per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a consumer residing in the living unit receives on-site staff supervision for 19 or more hours during a 24-hour calendar day and the consumer's individual comprehensive plan identifies and reflects the need for this amount of supervision.

(2) One hour when subparagraph (1) does not apply.

f. The maximum numbers of units available per consumer are as follows:

(1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.

(2) 8,395 hourly units are available per state fiscal year except a leap year, when 8,418 hourly units are available.

g. The service shall be identified in the consumer's individual comprehensive plan.

h. Services shall not be simultaneously reimbursed with other residential services, HCBS brain injury waiver respite, transportation or personal assistance services, Medicaid nursing, or Medicaid home health aide services.

78.43(3) *Respite services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would

provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer'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. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

e. Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS brain injury waiver supported community living services, Medicaid nursing, or Medicaid home health aide services.

f. The interdisciplinary team shall determine if the consumer will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.81(249A).

g. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

h. 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.

78.43(4) *Supported employment services.* Supported employment services are individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs *"a"* and *"b"* that address the disability-related challenges to securing and keeping a job.

a. Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a consumer for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the consumer and the interdisciplinary team described in rule 441—83.87(249A) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet the consumer's employment needs. Second, the consumer's interdisciplinary team must determine that the identified services are necessary. Third, the consumer's case manager must approve the services. Available components of activities to obtain a job are as follows:

(1) Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the consumer holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A consumer may receive two units of job development services during a 12-month period. The activities provided to the consumer may include:

1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.

2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.

3. Customized job development services specific to the consumer.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining consumers in their workforce and to communicate expectations of the employers to the interdisciplinary team described in rule 441—83.87(249A). Employer development services may be provided only to consumers who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the consumer holds for 30 consecutive calendar days or more. Payment for this service may be made only after the consumer holds the job for 30 days. A consumer may receive two units of employer development services during a 12-month

period if the consumer is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:

1. Developing relationships with employers and providing leads for individual consumers when appropriate.
2. Job analysis for a specific job.
3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.
4. Identifying and arranging reasonable accommodations with the employer.
5. Providing disability awareness and training to the employer when it is deemed necessary.
6. Providing technical assistance to the employer regarding the training progress as identified on the consumer's customized training plan.

(3) Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided to the consumer for a minimum of 30 days or with assisting the consumer in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the consumer's employment goals. A unit of service is an hour. A maximum of 26 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the consumer.
2. Assistance with applying for a job, including completion of applications or interviews.
3. Work site assessment and job accommodation evaluation.

b. Supports to maintain employment.

(1) Covered services provided to or on behalf of the consumer associated with maintaining competitive paid employment are the following:

1. Individual work-related behavioral management.
2. Job coaching.
3. On-the-job or work-related crisis intervention.
4. Assisting the consumer to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
5. Consumer-directed attendant care services as defined in subrule 78.43(13).
6. Assistance with time management.
7. Assistance with appropriate grooming.
8. Employment-related supportive contacts.
9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.
10. On-site vocational assessment after employment.
11. Employer consultation.

(2) Services for maintaining employment may include services associated with sustaining consumers in a team of no more than eight individuals with disabilities in a teamwork or "enclave" setting.

(3) A unit of service is one hour.

(4) A maximum of 40 units may be received per week.

c. The following requirements apply to all supported employment services:

(1) Employment-related adaptations required to assist the consumer within the performance of the consumer's job functions shall be provided by the provider as part of the services.

(2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.

(3) The majority of coworkers at any employment site with more than two employees where consumers seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where consumers seek, obtain, or maintain employment, the consumer must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.

(5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each consumer.

(6) All services shall be identified in the consumer's service plan maintained pursuant to rule 441—83.67(249A).

(7) The following services are not covered:

1. Services involved in placing or maintaining consumers in day activity programs, work activity programs or sheltered workshop programs;
2. Supports for volunteer work or unpaid internships;
3. Tuition for education or vocational training; or
4. Individual advocacy that is not consumer specific.

(8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

78.43(5) *Home and vehicle modifications.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer'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, roof repair, or adding square footage to the residence, are excluded except as specifically included below. 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 consumer'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 department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications. Payment of up to $6,060 per year may be made to certified providers upon satisfactory completion of the service. The service worker shall encumber up to $505 per month within the monthly dollar cap allowed for the consumer until the amount of the modification is reached within the 12-month period.

h. Services shall be included in the consumer's service plan and shall exceed the Medicaid state plan services.

78.43(6) *Personal emergency response system.* The personal emergency response system allows a consumer experiencing a medical emergency at home to activate electronic components that transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The necessary components of a system are:

a. An in-home medical communications transceiver.

b. A remote, portable activator.

c. A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days per week.

d. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each consumer.

e. The service shall be identified in the consumer's individual and comprehensive plan.

f. A unit is a one-time installation fee or one month of service.

g. Maximum units per state fiscal year are the initial installation and 12 months of service.

78.43(7) *Transportation.* Transportation services may be provided for consumers to conduct business errands and essential shopping, to receive medical services when not reimbursed through medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service.

78.43(8) *Specialized medical equipment.* Specialized medical equipment shall include medically necessary items for personal use by consumers with a brain injury which provide for health and safety of the consumer which are not ordinarily covered by Medicaid, and are not funded by educational or vocational rehabilitation programs, and are not provided by voluntary means. This includes, but is not limited to: electronic aids and organizers, medicine dispensing devices, communication devices, bath aids, and noncovered environmental control units. This includes repair and maintenance of items purchased through the waiver in addition to the initial purchase cost.

a. Consumers may receive specialized medical equipment once per month until a maximum yearly usage of $6,060 has been reached.

b. The need for specialized medical equipment shall be documented by a health care professional as necessary for the consumer's health and safety and identified in the consumer's individual comprehensive plan.

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 a full day (4 to 8 hours) or a half day (1 to 4 hours) or an extended day (8 to 12 hours). Components of the service are set forth in rule 441—171.6(234).

78.43(10) *Family counseling and training services.* Family counseling and training services are face-to-face mental health services provided to the consumer and the family with whom the consumer lives, or who routinely provide care to the consumer to increase the consumer's or family members' capabilities to maintain and care for the consumer in the community. Counseling may include helping the consumer or the consumer's family members with crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects of a brain injury. It may include the use of treatment regimes as specified in the ITP. Periodic training updates may be necessary to safely maintain the consumer in the community.

Family may include spouse, children, friends, or in-laws of the consumer. Family does not include individuals who are employed to care for the consumer.

78.43(11) *Prevocational services.* Prevocational services are services aimed at preparing a consumer eligible for the HCBS brain injury waiver for paid or unpaid employment, but which are not job task oriented. These services include teaching the consumer concepts necessary as job readiness skills, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities which are not primarily directed at teaching specific job skills but more generalized habilitative goals and are reflected in a habilitative plan which focuses on general habilitative rather than specific employment objectives.

Prevocational services do not include services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) which are otherwise available to the individual through a state or local education agency or vocational rehabilitation services which are otherwise available to the individual through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

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 consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding of performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program before accessing the HCBS waiver.

(1) Tube feedings of consumers 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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy.

(9) Care of medical conditions out of control which includes 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.

c. A unit of service is 1 hour, or one 8- to 24-hour day provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker or case manager prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer'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.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.43(14) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. The services must be needed to allow the consumer's usual caregivers to be employed or, for a limited period of time, for academic or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver.

a. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each consumer's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a consumer with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.

b. Interim medical monitoring and treatment services may include supervision to and from school.

c. Limitations.

(1) A maximum of 12 one-hour units 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.

(4) Interim medical monitoring and treatment services may be provided only in the consumer's home, in a registered group child care home, in a registered family child care home, in a licensed child care center, or during transportation to and from school.

(5) The staff-to-consumer ratio shall not be less than one to six.

d. A unit of service is one hour.

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).

(3) Schedule the provision of services.

(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.

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]

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) Teleconsultive services. Rescinded IAB 9/6/00, effective 11/1/00.

441—78.46(249A) Physical disability waiver service. Payment shall be approved for the following services to consumers eligible for the HCBS physical disability waiver established in 441—Chapter

83 when identified in the consumer's service plan. All services shall include the applicable and necessary instructions, supervision, assistance and support as required by the consumer in achieving the goals written specifically in the service plan and those delineated in Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. The service shall be delivered in the least restrictive environment consistent with the consumer's needs and in conformity with the consumer's service plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through regular Medicaid or from any other funding source.

All services shall be billed in whole units as specified in the following subrules.

78.46(1) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities listed below performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able. The services must be cost-effective and necessary to prevent institutionalization.

Providers must demonstrate proficiency in delivery of the services in the consumer's plan of care. Proficiency must be demonstrated through documentation of prior training or experience or a certificate of formal training. All training or experience will be detailed on Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, which must be reviewed and approved by the service worker for appropriateness of training or experience prior to the provision of services. Form 470-3372 becomes an attachment to and part of the case plan. Consumers shall give direction and training for activities which are not medical in nature to maintain independence. Licensed registered nurses and therapists must provide on-the-job training and supervision to the provider for skilled activities listed below and described on Form 470-3372. The training and experience must be sufficient to protect the health, welfare and safety of the consumer.

a. Nonskilled service activities covered are:

(1) Help with dressing.

(2) Help with bath, shampoo, hygiene, and grooming.

(3) Help with access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance which includes emptying the catheter bag, collecting a specimen and cleaning the external area around the catheter. Certification of training which includes demonstration of competence for catheter assistance is available through the area community colleges.

(5) Meal preparation, cooking, eating and feeding assistance but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer's health care at home.

(7) Help with medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. Certification of training in a medication aide course is available through the area community colleges.

(8) Minor wound care which does not require skilled nursing care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the consumer is on the job site. The cost of transportation for the consumer and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistance in use of assistive devices for communication.

(12) Assisting and accompanying a consumer in using transportation essential to the health and welfare of the consumer, but not the cost of the transportation.

b. Skilled service activities covered are the following performed under the supervision of a licensed nurse or licensed therapist working under the direction of a licensed physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present.

The cost of the supervision provided by the licensed nurse or therapist shall not be included in the reimbursement for consumer-directed attendant care services.

(1) Tube feedings of consumers unable to eat solid foods.

(2) Assistance with intravenous therapy which is 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 bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions such as brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nurse-delegated activities under the supervision of the registered nurse.

(11) Monitoring medication reactions 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.

c. A unit of service is 1 hour for up to 7 hours per day or one 8- to 24-hour day provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the consumer.

f. The service activities may not include parenting or child care on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the consumer'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.

i. If the consumer has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the consumer, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.46(2) *Home and vehicle modifications.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer'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, roof repair, or adding square footage to the residence, are excluded except as specifically included below. 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 consumer'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 department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications. Payment of up to $6,060 per year may be made to certified providers upon satisfactory completion of the service. The service worker shall encumber up to $505 per month within the monthly dollar cap allowed for the consumer until the amount of the modification is reached within the 12-month period.

h. Services shall be included in the consumer's service plan and shall exceed the Medicaid state plan services.

78.46(3) *Personal emergency response system.* The personal emergency response system allows a consumer experiencing a medical emergency at home to activate electronic components that transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The service shall be identified in the consumer's service plan. A unit is a one-time installation fee or one month of service. Maximum units per state fiscal year are the initial installation and 12 months of service. The necessary components of a system are:

a. An in-home medical communications transceiver.

b. A remote, portable activator.

c. A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days a week.

d. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each consumer.

78.46(4) *Specialized medical equipment.* Specialized medical equipment shall include medically necessary items for personal use by consumers with a physical disability which provide for the health and safety of the consumer that are not covered by Medicaid, are not funded by vocational rehabilitation programs, and are not provided by voluntary means. This includes, but is not limited to: electronic aids and organizers, medicine-dispensing devices, communication devices, bath aids and noncovered environmental control units. This includes repair and maintenance of items purchased through the waiver in addition to the initial costs.

a. Consumers may receive specialized medical equipment once a month until a maximum yearly usage of $6,060 has been reached.

b. The need for specialized medical equipment shall be documented by a health care professional as necessary for the consumer's health and safety and shall be identified in the consumer's service plan.

78.46(5) *Transportation.* Transportation services may be provided for consumers to conduct business errands and essential shopping, to receive medical services when not reimbursed through Medicaid as medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging.

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).

(3) Schedule the provision of services.

(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.

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

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10]

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) Rehabilitation services for adults with chronic mental illness. Rescinded IAB 8/1/07, effective 9/5/07.

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. Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as local education agency services. Agencies that wish to administer those

vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. However, the administration of vaccines is a covered service.

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.

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 consumers eligible for the HCBS children's mental health waiver as established in 441—Chapter 83. All services shall be provided in accordance with the general standards in subrule 78.52(1), as well as standards provided specific to each waiver service in subrules 78.52(2) through 78.52(5).

78.52(1) *General service standards.* All children's mental health waiver services shall be provided in accordance with the following standards:

a. Services must be based on the consumer's needs as identified in the consumer's service plan developed pursuant to 441—83.127(249A).

(1) Services must be delivered in the least restrictive environment consistent with the consumer's needs.

(2) Services must include the applicable and necessary instruction, supervision, assistance and support as required by the consumer to achieve the consumer's goals.

b. Payment for services shall be made only upon departmental approval of the services. Waiver services provided before approval of the consumer's eligibility for the waiver shall not be paid.

c. Services or service components must not be duplicative.

(1) Reimbursement shall not be available under the waiver for any services that the consumer may obtain through the Iowa Medicaid program outside of the waiver.

(2) Reimbursement shall not be available under the waiver for any services that the consumer may obtain through natural supports or community resources.

(3) Services may not be simultaneously reimbursed for the same period as nonwaiver Medicaid services or other Medicaid waiver services.

(4) Costs for waiver services are not reimbursable while the consumer is in a medical institution.

78.52(2) *Environmental modifications and adaptive devices.*

a. Environmental modifications and adaptive devices include items installed or used within the consumer's home that address specific, documented health, mental health, or safety concerns.

b. A unit of service is one modification or device.

c. For each unit of service provided, the case manager shall maintain in the consumer's case file a signed statement from a mental health professional on the consumer's interdisciplinary team that the service has a direct relationship to the consumer's diagnosis of serious emotional disturbance.

78.52(3) *Family and community support services.* Family and community support services shall support the consumer and the consumer'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 consumer's and the family's social and emotional strength.

a. Dependent on the needs of the consumer and the consumer's family members individually or collectively, family and community support services may be provided to the consumer, to the consumer's family members, or to the consumer 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 consumer's interdisciplinary team pursuant to 441—83.127(249A).

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 consumer and for the consumer's family.

(2) Modeling and coaching effective coping strategies for the consumer's family members.

(3) Building resilience to the stigma of serious emotional disturbance for the consumer 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 consumer's crisis intervention plan as defined in 441—24.1(225C) for life situations with the consumer's family and in the community.

(6) Developing medication management skills.

(7) Developing personal hygiene and grooming skills that contribute to the consumer'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 consumer 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 identify the transportation or therapeutic resource as a support need.

(2) The annual amount available for transportation and therapeutic resources must be listed in the consumer's service plan.

(3) The consumer's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the consumer or the consumer's family or legal guardian.

(4) The consumer's Medicaid targeted 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.

(6) Family and community support services providers shall maintain records to:

1. Ensure that the transportation and therapeutic resources provided to not exceed the maximum amount authorized; and

2. Support the annual reporting requirements in 441—subparagraph 79.1(15)*"a"*(1).

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 consumer care.

f. A unit of family and community support services is one hour.

78.52(4) *In-home family therapy.* In-home family therapy provides skilled therapeutic services to the consumer 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 consumer 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 one hour. Any period less than one hour shall be prorated.

78.52(5) *Respite care services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The "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.

a. Respite care shall not be provided to consumers during the hours in which the usual caregiver is employed, except when the consumer is attending a camp.

b. The usual caregiver cannot be absent from the home for more than 14 consecutive days during respite provision.

c. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team. The team shall determine the type of respite care to be provided according to these definitions:

(1) Basic individual respite is provided on a ratio of one staff to one consumer. The consumer does not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

(2) Specialized respite is provided on a ratio of one or more nursing staff to one consumer. The consumer has specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

(3) Group respite is provided on a ratio of one staff to two or more consumers receiving respite. These consumers do not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

d. Respite services provided for a period exceeding 24 consecutive hours to three or more consumers 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.

e. Respite services provided outside the consumer'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.

f. A unit of service is one hour.

This rule is 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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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.

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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.

CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 79]

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

79.1(1) *Types of reimbursement.*

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

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

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

(1) The actual charge made by the provider of service.

(2) The maximum allowance under the fee schedule for the item of service in question.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Provider category	Basis of reimbursement	Upper limit
1. Adult day care	Fee schedule	For AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Veterans Administration contract rate or $21.57 per half-day, $42.93 per full day, or $64.38 per extended day if no Veterans Administration contract. For intellectual disability waiver: County contract rate or, in the absence of a contract rate, $28.73 per half-day, $57.36 per full day, or $73.13 per extended day.
2. Emergency response system	Fee schedule	Initial one-time fee $48.29. Ongoing monthly fee $37.56.
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and ill and handicapped waivers: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%. For intellectual disability waiver: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%, converted to an hourly rate.
4. Homemakers	Fee schedule	Maximum of $19.31 per hour.
5. Nursing care	For elderly and intellectual disability waivers: Fee schedule as determined by Medicare.	For elderly waiver: $80.85 per visit. For intellectual disability waiver: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%, converted to an hourly rate.
	For AIDS/HIV and ill and handicapped waivers: Agency's financial and statistical cost report and Medicare percentage rate per visit.	For AIDS/HIV and ill and handicapped waivers: Cannot exceed $80.85 per visit.
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Cost-based rate for nursing services provided by a home health agency	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 2.5%, converted to an hourly rate, not to exceed $296.94 per day.

Provider category	Basis of reimbursement	Upper limit
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 2.5%, converted to an hourly rate, not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.79 per hour not to exceed $296.94 per day.
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$32.91 per hour not to exceed $296.94 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$17.56 per hour not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.79 per hour not to exceed $296.94 per day.
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$32.91 per hour not to exceed $296.94 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$17.56 per hour not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.79 per hour not to exceed $296.94 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	$12.79 per hour not to exceed daily per diem for skilled nursing facility level of care.
Nursing facility	Fee schedule	$12.79 per hour not to exceed daily per diem for nursing facility level of care.
Camps	Retrospectively limited prospective rates. See 79.1(15)	$12.79 per hour not to exceed $296.94 per day.
Adult day care	Fee schedule	$12.79 per hour not to exceed rate for regular adult day care services.
Intermediate care facility for the mentally retarded	Fee schedule	$12.79 per hour not to exceed daily per diem for ICF/MR level of care.
Residential care facilities for persons with mental retardation	Fee schedule	$12.79 per hour not to exceed contractual daily per diem.
Foster group care	Fee schedule	$12.79 per hour not to exceed daily per diem rate for child welfare services.
Child care facilities	Fee schedule	$12.79 per hour not to exceed contractual daily per diem.
7. Chore service	Fee schedule	$7.52 per half hour.
8. Home-delivered meals	Fee schedule	$7.52 per meal. Maximum of 14 meals per week.

Provider category	Basis of reimbursement	Upper limit
9. Home and vehicle modification	Fee schedule	For elderly waiver: $1,010 lifetime maximum. For intellectual disability waiver: $5,050 lifetime maximum. For brain injury, ill and handicapped and physical disability waivers: $6,060 per year.
10. Mental health outreach providers	Fee schedule	On-site Medicaid reimbursement rate for center or provider. Maximum of 1440 units per year.
11. Transportation	Fee schedule	County contract rate or, in the absence of a contract rate, the rate set by the area agency on aging.
12. Nutritional counseling	Fee schedule	$8.04 per unit.
13. Assistive devices	Fee schedule	$107.30 per unit.
14. Senior companion	Fee schedule	$6.44 per hour.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	$19.70 per hour not to exceed the daily rate of $113.80 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	For elderly waiver only: $1,089.08 per calendar month. Rate must be prorated per day for a partial month, at a rate not to exceed $35.79 per day.
Individual	Fee agreed upon by member and provider	Effective July 1, 2010, $13.47 per hour not to exceed the daily rate of $78.56 per day.
16. Counseling		
Individual:	Fee schedule	$10.52 per unit.
Group:	Fee schedule	$42.06 per hour.
17. Case management	Fee schedule with cost settlement. See 79.1(1)*"d."*	For brain injury waiver: Retrospective cost-settled rate. For elderly waiver: Quarterly revision of reimbursement rate as necessary to maintain projected expenditures within the amounts budgeted under the appropriations made for the medical assistance program for the fiscal year.
18. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	$34.11 per hour, $76.91 per day not to exceed the maximum daily ICF/MR per diem less 2.5%.
19. Supported employment:		
Activities to obtain a job:		

Provider category	Basis of reimbursement	Upper limit
Job development	Fee schedule	$886.28 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	$886.28 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospectively limited prospective rates. See 79.1(15)	Maximum of $34.11 per hour and 26 hours per 12 months.
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Maximum of $34.11 per hour for all activities other than personal care and services in an enclave setting. Maximum of $19.31 per hour for personal care. Maximum of $6.04 per hour for services in an enclave setting. Total not to exceed $2,811.62 per month. Maximum of 40 units per week.
20. Specialized medical equipment	Fee schedule	$6,060 per year.
21. Behavioral programming	Fee schedule	$10.52 per 15 minutes.
22. Family counseling and training	Fee schedule	$42.06 per hour.
23. Prevocational services	Fee schedule	For the brain injury waiver: $36.50 per day. For the intellectual disability waiver: County contract rate or, in absence of a contract rate, $47.01 per day.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%, converted to an hourly rate.
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%, converted to an hourly rate.
Child development home or center	Fee schedule	$12.79 per hour.
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	The maximum daily per diem for ICF/MR less 2.5%.
26. Day habilitation	Fee schedule	County contract rate or, in the absence of a contract rate, $12.88 per hour, $31.35 per half-day, or $62.68 per day.
27. Environmental modifications and adaptive devices	Fee schedule	$6,060 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	$34.11 per hour.
29. In-home family therapy	Fee schedule	$91.29 per hour.

Provider category	Basis of reimbursement	Upper limit
30. Financial management services	Fee schedule	$64.01 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	$14.77 per hour.
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget.
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget.
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule with cost settlement. See 79.1(1)*"d."*	Retrospective cost-settled rate.
2. Home-based habilitation	Retrospective cost-related. See 79.1(24)	$46.70 per hour or $105.97 per day.
3. Day habilitation	Retrospective cost-related. See 79.1(24)	$13.21 per hour, $32.15 per half-day, or $64.29 per day.
4. Prevocational habilitation	Retrospective cost-related. See 79.1(24)	$9.91 per hour, $24.11 per half-day, or $48.22 per day.
5. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospective cost-related. See 79.1(24)	Maximum of $34.98 per hour and 26 hours per 12 months.
Supports to maintain employment	Retrospective cost-related. See 79.1(24)	$6.19 per hour for services in an enclave setting; $19.81 per hour for personal care; and $34.98 per hour for all other services. Total not to exceed $2,883.71 per month. Maximum of 40 units per week.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, home health aide, and medical social services; home health care for maternity patients and children	Retrospective cost-related	Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09 less 5%.
2. Private duty nursing and personal care for persons aged 20 or under	Interim fee schedule with retrospective cost settlement	Medicaid rate in effect 11/30/09 less 5%.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14)*"d"*)

Provider category	Basis of reimbursement	Upper limit
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1)*"g"* and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 11/30/09 less 5%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16)*"c"*	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 11/30/09 less 5%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health service 638 facilities	1. Base rate as determined by the United States Office of Management and Budget for outpatient visits for American Indian and Alaskan native members.	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 the mentally retarded	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Local education agency services providers	Fee schedule	Fee schedule.
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 11/30/09 less 5%.
Nursing facilities: 1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(1)"1" and (2)"1" is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of	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
	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.	
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 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16)*"f."* The direct care rate component limit under 441—81.6(16)*"f"*(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)*"f"*(3) is 110% of the patient-day-weighted median.
Occupational therapists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).

Provider category	Basis of reimbursement	Upper limit
Pharmacy administration of influenza vaccine to children	Physician fee schedule for immunization administration	Fee schedule in effect 11/30/09 less 5%.
Physical therapists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)*"a"*	Fee schedule in effect 11/30/09 less 5%.
Anesthesia services	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Podiatrists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Prescribed drugs	See 79.1(8)	$4.34 dispensing fee. (See 79.1(8)*"a," "b,"* and *"e."*)
Psychiatric medical institutions for children		
1. Inpatient	Retrospective cost-related	Actual and allowable cost not to exceed a maximum for non-state-owned providers of 103% of patient-day-weighted average costs of non-state-owned providers located within Iowa less 5%.
2. Outpatient day treatment	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Psychologists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Rehabilitation agencies	Fee schedule	Medicare fee schedule less 5%; refer to 79.1(21).
Remedial services	Retrospective cost-related. See 79.1(23)	110% of average cost less 5%.
Rural health clinics	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
Screening centers	Fee schedule	Reimbursement rate for center in effect 11/30/09 less 5%.
State-operated institutions	Retrospective cost-related	
Targeted case management providers	Fee for service with cost settlement. See 79.1(1)*"d."*	Retrospective cost-settled rate.

79.1(3) *Ambulatory surgical centers.*

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

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

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

79.1(5) *Reimbursement for hospitals.*

a. Definitions.

"Adolescent" shall mean a Medicaid patient 17 years or younger.

"Adult" shall mean a Medicaid patient 18 years or older.

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

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

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

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

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

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

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

For purposes of calculating the disproportionate share rate only, separate capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's

hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"GME/DSH fund implementation year" means 2009.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Rebasing implementation year" means 2008 and every three years thereafter.

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

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

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

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

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

(2) Neonatal intensive care units certified pursuant to 79.1(5)*"r."* Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating

neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization. The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

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

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

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

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

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

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

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

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

1. The total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and
2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services rendered on or after October 1, 2006, and indirect medical education.

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

(2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base-year cost report or MMIS claims system, the actual dollar expenditures for capital costs,

direct medical education costs, and the payments made for nonfull DRG transfers, outliers, physical rehabilitation services, and psychiatric services rendered on or after October 1, 2006, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

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

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

e. Add-ons to the base amount.

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

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

Allowable capital costs are determined by multiplying the capital amount from the base-year cost report by 80 percent. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

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

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

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

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

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

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

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

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

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

g. Billing for patient transfers and readmissions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

k. Inflation factors, rebasing, and recalibration.

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

(2) Base amounts shall be rebased and weights recalibrated in 2005 and every three years thereafter. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the calendar year preceding the rebasing

implementation year. If a hospital does not provide this cost report to the Iowa Medicaid enterprise provider cost audits and rate-setting unit by May 31 of a rebasing implementation year, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

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

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

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

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

m. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year will receive a case-mix-adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

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

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

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

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

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

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

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

1. The patient's name, state identification number, and date of admission;
2. A brief summary of the case;

3. A current listing of charges; and

4. A physician's attestation that the recipient has been an inpatient for 120 days and is expected to remain in the hospital for a period of no less than 60 additional days.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Advertising.

(2) Promotional items.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Base year cost reports.

2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. Final settlement for state-owned teaching hospital.

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

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus

2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus

3. $9,900,000.

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

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

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

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

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

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

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

79.1(7) *Physicians.*

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

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

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

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

(1) The estimated acquisition cost, defined:

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

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

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

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

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

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

(1) The estimated acquisition cost, defined:

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

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

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

c. No payment shall be made for sales tax.

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

e. The basis of payment for nonprescription drugs shall be the same as specified in paragraph *"a"* except that the department shall establish a maximum allowable reimbursable cost for these drugs using the average wholesale prices of the chemically equivalent products available. The department shall set the maximum allowable reimbursable cost at the median of those average wholesale prices. No exceptions for higher reimbursement will be approved.

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

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

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

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

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

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

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

79.1(9) *HCBS consumer choices financial management.*

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

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

perform a cost settlement. The cost settlement represents the difference between the amount received for the allocated individual budget and the amount actually utilized.

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

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

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

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

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

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

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

79.1(10) *Prohibition against reassignment of claims.* No payment under the medical assistance program for any care or service provided to a patient by any health care provider shall be made to anyone other than the providers. However with respect to physicians, dentists or other individual practitioners direct payment may be made to the employer of the practitioner if the practitioner is required as a condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to a foundation, plan or similar organization including a health maintenance organization which furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person's services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, which renders statements and receives payment in the name of the provider when the agent's compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule shall preclude making payment to the estate of a deceased practitioner.

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

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

be the lowest charge levels determined by the department according to the Medicare reimbursement method.

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

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

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

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

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

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

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

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

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

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

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

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

d. The member shall pay $3 copayment for:

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

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

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

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

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

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

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

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

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

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

(2) Serious impairment to bodily functions, or

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

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

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

79.1(14) *Reimbursement for hospice services.*

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

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

(1) Routine home care.

(2) Continuous home care.

(3) Inpatient respite care.

(4) General inpatient care.

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

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

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

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

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

e. Limitation of payments for inpatient care. Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the

hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

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

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

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

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.
2. Multiplying excess inpatient care days by the routine home care rate.
3. Adding together the amounts calculated in "1" and "2."
4. Comparing the amount in "3" with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement shall be refunded by the hospice.

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

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

a. Reporting requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c. Prospective rates for new providers other than respite.

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

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

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

d. Prospective rates for established providers other than respite.

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

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

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

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

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

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

f. Retrospective adjustments.

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

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

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

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

79.1(16) *Outpatient reimbursement for hospitals.*

a. Definitions.

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

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

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

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

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

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

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

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

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

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

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

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

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following

formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

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

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

"GME/DSH fund implementation year" means 2009.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Quality improvement organization" or *"QIO"* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding

information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

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

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

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

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

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate-setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital's financial and statistical report.

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

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

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

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

c. Payment for outpatient hospital services.

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

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

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

(3) The APC payment is calculated as follows:

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

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

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

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

Indicator	Item, Code, or Service	OPPS Payment Status
A	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.

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.

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.
V	Clinic or emergency department visit	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.

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 that APC payment amounts for out-of-state hospitals may be based on either the Iowa statewide base APC rate or the Iowa blended base APC rate for the out-of-state hospital.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

v. Graduate medical education and disproportionate share fund. Payment shall be made to all hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated

to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

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

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

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

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

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

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

w. Final settlement for state-owned teaching hospital.

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

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

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

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

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

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

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

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 Dental Terminology, Third Edition (CDT-3).

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

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

a. Definitions. For purposes of this subrule:

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

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

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

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

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

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

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

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

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

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

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

79.1(23) *Reimbursement for remedial services.* Reimbursement for remedial services 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.

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

(6) A projected cost report shall be submitted when a new remedial services provider enters the program or an existing remedial 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. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

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

(2) When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount received by the

provider through an interim rate during the year for covered services and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(24) *Reimbursement for home- and community-based habilitation services.* Reimbursement for case management, job development, and employer development is based on a fee schedule developed using the methodology described in paragraph 79.1(1)*"d."* Reimbursement for home-based habilitation, day habilitation, prevocational habilitation, enhanced job search and supports to maintain employment is based on a retrospective cost-related rate calculated using the methodology in this subrule. All rates are subject to the upper limits established in subrule 79.1(2).

a. Units of service.

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

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

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

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

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

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

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

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

2. One hour for enhanced job search.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

79.2(1) *Definitions.*

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

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

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

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

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

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

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

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

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

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

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

b. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled, including charges in excess of usual and customary charges.

c. Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

d. Failure to disclose or make available to the department or its authorized agent, records of services provided to medical assistance recipients and records of payments made for those services.

e. Failure to provide and maintain the quality of services to medical assistance recipients within accepted medical community standards as adjudged by professional peers.

f. Engaging in a course of conduct or performing an act which is in violation of state or federal regulations of the medical assistance program, or continuing that conduct following notification that it should cease.

g. Failure to comply with the terms of the provider certification on each medical assistance check endorsement.

h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing the recipient to receive services or merchandise not required or requested by the recipient.

i. Rebating or accepting a fee or portion of a fee or a charge for medical assistance patient referral.

j. Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto.

k. Submission of a false or fraudulent application for provider status under the medical assistance program.

l. Violations of any laws, regulations, or code of ethics governing the conduct of occupations or professions or regulated industries.

m. Conviction of a criminal offense relating to performance of a provider agreement with the state or for negligent practice resulting in death or injury to patients.

n. Failure to meet standards required by state or federal law for participation, for example, licensure.

o. Exclusion from Medicare because of fraudulent or abusive practices.

p. Documented practice of charging recipients for covered services over and above that paid for by the department, except as authorized by law.

q. Failure to correct deficiencies in provider operations after receiving notice of these deficiencies from the department.

r. Formal reprimand or censure by an association of the provider's peers for unethical practices.

s. Suspension or termination from participation in another governmental medical program such as workers' compensation, crippled children's services, rehabilitation services or Medicare.

t. Indictment for fraudulent billing practices, or negligent practice resulting in death or injury to the provider's patients.

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

a. A term of probation for participation in the medical assistance program.

b. Termination from participation in the medical assistance program.

c. Suspension from participation in the medical assistance program. This includes when the department is notified by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, that a practitioner has been suspended from participation under the Medicare program. These practitioners shall be suspended from participation in the medical assistance program effective

on the date established by the Centers for Medicare and Medicaid Services and at least for the period of time of the Medicare suspension.

d. Suspension or withholding of payments to provider.

e. Referral to peer review.

f. Prior authorization of services.

g. One hundred percent review of the provider's claims prior to payment.

h. Referral to the state licensing board for investigation.

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

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

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

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

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

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

(1) Seriousness of the offense.

(2) Extent of violations.

(3) History of prior violations.

(4) Prior imposition of sanctions.

(5) Prior provision of provider education.

(6) Provider willingness to obey program rules.

(7) Whether a lesser sanction will be sufficient to remedy the problem.

(8) Actions taken or recommended by peer review groups or licensing boards.

79.2(5) *Scope of sanction.*

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

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

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

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

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

79.2(7) *Notice of violation.* Should the department have information that indicates that a provider may have submitted bills or has been practicing in a manner inconsistent with the program requirements,

or may have received payment for which the provider may not be properly entitled, the department shall notify the provider of the discrepancies noted. Notification shall set forth:

a. The nature of the discrepancies or violations,

b. The known dollar value of the discrepancies or violations,

c. The method of computing the dollar value,

d. Notification of further actions to be taken or sanctions to be imposed by the department, and

e. Notification of any actions required of the provider. The provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken.

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

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

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

79.3(1) *Financial (fiscal) records.*

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

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

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

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

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

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

(1) The provision of each service and each activity billed to the program; and

(2) First and last name of the member receiving the service.

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

(1) Medically necessary;

(2) Consistent with the diagnosis of the member's condition; and

(3) Consistent with professionally recognized standards of care.

c. Components.

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

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

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.
11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.
13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

(3) Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided and shall include the following:

1. The specific procedures or treatments performed.
2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. For those time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.
4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5)*"c"* or *"d,"* 441—paragraph 77.33(6)*"d,"* 441—paragraph 77.34(5)*"d,"* 441—paragraph 77.37(15)*"d,"* 441—paragraph 77.39(13)*"e,"* 441—paragraph 77.39(14)*"d,"* or 441—paragraph 77.46(5)*"i,"* or 441—subparagraph 78.9(10)*"a"*(1).
5. The name, dosage, and route of administration of any medication dispensed or administered as part of the service.
6. Any supplies dispensed as part of the service.
7. The first and last name and professional credentials, if any, of the person providing the service.
8. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.
9. For 24-hour care, documentation for every shift of the services provided, the member's response to the services provided, and the person who provided the services.

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

d. Basis for service requirements for specific services. The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it). These items will be specified on Form 470-4479, Documentation Checklist, when the Iowa Medicaid enterprise surveillance and utilization review services 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) Remedial services and rehabilitation services for adults with a chronic mental illness:
1. Order for services.
2. Comprehensive treatment or service plan (initial and subsequent).
3. Service notes or narratives.

(26) Services provided by area education agencies and local education agencies:
1. Service notes or narratives.
2. Individualized education program (IEP).
3. Individual health plan (IHP).
4. Behavioral intervention plan.

(27) Home health agency services:
1. Plan of care or plan of treatment.
2. Certifications and recertifications.
3. Service notes or narratives.
4. Physician orders or medical orders.

(28) Services provided by independent laboratories:
1. Laboratory reports.
2. Physician order for each laboratory test.

(29) Ambulance services:

1. Documentation on the claim or run report supporting medical necessity of the transport.
2. Documentation supporting mileage billed.

(30) Services of lead investigation agencies:

1. Service notes or narratives.
2. Child's lead level logs (including laboratory results).
3. Written investigation reports to family, owner of building, child's medical provider, and local childhood lead poisoning prevention program.
4. Health education notes, including follow-up notes.

(31) Medical supplies:

1. Prescriptions.
2. Certificate of medical necessity.
3. Prior authorization documentation.
4. Medical equipment invoice or receipt.

(32) Orthopedic shoe dealer services:

1. Service notes or narratives.
2. Prescriptions.
3. Certifying physician's statement.

(33) Case management services, including HCBS case management services:

1. Form 470-3956, MR/CMI/DD Case Management Service Authorization Request, for services authorized before May 1, 2007.
2. Notice of decision for service authorization.
3. Service notes or narratives.
4. Social history.
5. Comprehensive service plan.
6. Reassessment of member needs.
7. Incident reports in accordance with 441—subrule 24.4(5).

(34) Early access service coordinator services:

1. Individualized family service plan (IFSP).
2. Service notes or narratives.

(35) Home- and community-based waiver services, other than case management:

1. Notice of decision for service authorization.
2. Service plan.
3. Service logs, notes, or narratives.
4. Mileage and transportation logs.
5. Log of meal delivery.
6. Invoices or receipts.
7. Forms 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record.

(36) Physical therapist services:

1. Physician order for physical therapy.
2. Initial physical therapy certification, recertifications, and treatment plans.
3. Treatment notes and forms.
4. Progress or status notes.

(37) Chiropractor services:

1. Service or office notes or narratives.
2. X-ray results.

(38) Hearing aid dealer and audiologist services:

1. Physician examinations and audiological testing (Form 470-0361, Sections A, B, and C).
2. Documentation of hearing aid evaluation and selection (Form 470-0828).
3. Waiver of informed consent.
4. Prior authorization documentation.
5. Service or office notes or narratives.

(39) Behavioral health services:

1. Assessment.
2. Individual treatment plan.
3. Service or office notes or narratives.

e. Corrections. A provider may correct the medical record before submitting a claim for reimbursement.

(1) Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

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

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

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

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

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

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

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

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

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

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 8262B**, IAB 11/4/09, effective 12/9/09]

441—79.4(249A) Reviews and audits.

79.4(1) *Definitions.*

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

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

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

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

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

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

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

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

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

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

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

"Universe" means all items or claims under review or audit during the period specified by the audit or review.

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

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

(1) The department has correctly paid claims for goods or services.

(2) The provider has furnished the services to Medicaid members.

(3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.

(4) The goods or services provided were in accordance with Iowa Medicaid policy.

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

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

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

Please sign this form and return it with the information requested.
Follow the checklist to ensure that all documents requested for each patient have been copied and enclosed with this request. The documentation must support the validity of the claim that was paid by the Medicaid program.
Please send copies. Do not send original records.
If you have any questions about this request or checklist, please contact the reviewer listed above.

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

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

Signature	Title	Telephone Number

470-4479 (4/08)

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

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

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

b. Extension of time limit for submission.

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

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

(2) Under exceptional circumstances, a provider may request one additional 15-calendar-day extension. The provider or the provider's designee shall submit a written request that:

1. Establishes exceptional circumstances for the delay in submitting records; and
2. Is received by the department before the expiration of the initial 15-day extension period.

(3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.

(4) The provider may appeal the department's denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.

c. The department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.

(1) For an announced on-site review or audit, the department's employee or authorized agent may give as little as one day's advance notice of the review or audit and the records and supporting documentation to be reviewed.

(2) Notice is not required for unannounced on-site reviews and audits.

(3) In an on-site review or audit, the conclusion of that review or audit shall be considered the end of the period within which to produce records.

d. Audit or review procedures may include, but are not limited to, the following:

(1) Comparing clinical and fiscal records with each claim.

(2) Interviewing members who received goods or services and employees of providers.

(3) Examining third-party payment records.

(4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.

(5) Examining all documents related to the services for which Medicaid was billed.

e. Use of statistical sampling techniques. The department's procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.

(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.

(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures shall constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

79.4(4) *Preliminary report of audit or review findings.* If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

79.4(5) *Disagreement with audit or review findings.* If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.

a. Reevaluation request. A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.

(1) If the audit or review is being performed by the Iowa Medicaid enterprise surveillance and utilization review services unit, the request should be addressed to: IME SURS Unit, P.O. Box 36390, Des Moines, Iowa 50315.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to: Iowa Department of Human Services, Attention: Fiscal Management Division, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. Additional information. A provider that has made a reevaluation request pursuant to paragraph *"a"* of this subrule may submit clarifying information or supplemental documentation that was not previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph *"c"* of this subrule.

c. Disagreement with sampling results. When the department's audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department's sample. Any such audit or review must:

(1) Be arranged and paid for by the provider.

(2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.

(3) Be conducted by a certified public accountant if the issues relate to fiscal records.

(4) Demonstrate that bills and records that were not audited or reviewed in the department's sample are in compliance with program regulations.

(5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

79.4(6) *Finding and order for repayment.* Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department shall issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

79.4(7) *Appeal by provider of care.* A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment.

This rule is intended to implement Iowa Code section 249A.4.

441—79.5(249A) Nondiscrimination on the basis of handicap. All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and Federal regulations 45 CFR Part 84, as amended to December 19, 1990, which prohibit discrimination on the basis of handicap in all Department of Health and Human Services funded programs.

This rule is intended to implement Iowa Code subsection 249A.4(6).

441—79.6(249A) Provider participation agreement. Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on Form 470-2965, Agreement Between Provider of Medical and Health Services and the Iowa Department of Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 441—79.3(249A).

79.6(2) That the charges as determined in accordance with the department's policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

79.6(3) That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

This rule is intended to implement Iowa Code section 249A.4.

441—79.7(249A) Medical assistance advisory council.

79.7(1) *Officers.* Officers shall be a chairperson and a vice-chairperson.

a. The director of public health shall serve as chairperson of the council. Elections for vice-chairperson will be held the first meeting after the beginning of the calendar year.

b. The vice-chairperson's term of office shall be two years. A vice-chairperson shall serve no more than two terms.

c. The vice-chairperson shall serve in the absence of the chairperson.

d. The chairperson and vice-chairperson shall have the right to vote on any issue before the council.

e. The chairperson shall appoint a committee of not less than three members to nominate vice-chairpersons and shall appoint other committees approved by the council.

79.7(2) *Membership.* The membership of the council and its executive committee shall be as prescribed at Iowa Code section 249A.4B, subsections 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. When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

79.8(1) *Making the request.*

a. Providers may submit requests for prior authorization for any items or procedures by mail or by facsimile transmission (fax) using Form 470-0829, Request for Prior Authorization, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs may also be made by telephone.

b. Providers shall send requests for prior authorization to the Iowa Medicaid enterprise. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought, according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-3970, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-3970 the attachment control number submitted on the ASC X12N 278 electronic transaction.

79.8(2) The policy applies to services or items specifically designated as requiring prior authorization.

79.8(3) The provider shall receive a notice of approval or denial for all requests.

a. In the case of prescription drugs, notices of approval or denial will be faxed to the prescriber and pharmacy.

b. Decisions regarding approval or denial will be made within 24 hours from the receipt of the prior authorization request. In cases where the request is received during nonworking hours, the time limit will be construed to start with the first hour of the normal working day following the receipt of the request.

79.8(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.8(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.8(6) If a provider is unsure if an item or service is covered because it is rare or unusual, the provider may submit a request for prior approval in the same manner as other requests for prior approval in 79.8(1).

79.8(7) Requests for prior approval of services shall be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

a. The conditions for payment outlined in the provider manual with reference to coverage and duration.

b. The determination made by the Medicare program unless specifically stated differently in state law or rule.

c. The recommendation to the department from the appropriate advisory committee.

d. Whether there are other less expensive procedures which are covered and which would be as effective.

e. The advice of an appropriate professional consultant.

79.8(8) The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of the policies is available in the provider manual distributed and updated to all participating providers.

79.8(9) The Iowa Medicaid enterprise shall issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 7. The Iowa Medicaid enterprise shall mail the notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

79.8(10) If a request for prior approval is denied by the Iowa Medicaid enterprise, the request may be resubmitted for reconsideration with additional information justifying the request. The aggrieved party may file an appeal in accordance with 441—Chapter 7.

This rule is intended to implement Iowa Code section 249A.4.

441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.9(1) Medicare definitions and policies shall apply to services provided unless specifically defined differently.

79.9(2) The services covered by Medicaid shall:

a. Be consistent with the diagnosis and treatment of the patient's condition.

b. Be in accordance with standards of good medical practice.

c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.

d. Be the least costly type of service which would reasonably meet the medical need of the patient.

e. Be eligible for federal financial participation unless specifically covered by state law or rule.

f. Be within the scope of the licensure of the provider.

g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.

h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

79.9(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.9(4) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

79.9(5) Coverage in public institutions. Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid.

This rule is intended to implement Iowa Code section 249A.4.

441—79.10(249A) Requests for preadmission review. The inpatient hospitalization of Medicaid recipients is subject to preadmission review by the Iowa Medicaid enterprise (IME) medical services unit as required in rule 441—78.3(249A).

79.10(1) The patient's admitting physician, the physician's designee, or the hospital will contact the IME medical services unit to request approval of Medicaid coverage for the hospitalization, according to instructions issued to providers by the IME medical services unit and instructions in the Medicaid provider manual.

79.10(2) Medicaid payment will not be made to the hospital if the IME medical services unit denies the procedure requested in the preadmission review.

79.10(3) The IME medical services unit shall issue a letter of denial to the patient, the physician, and the hospital when a request is denied. The patient, the physician, or the hospital may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.10(4) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit according to 441—Chapter 7.

79.10(5) The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter 88.

This rule is intended to implement Iowa Code section 249A.4.

441—79.11(249A) Requests for preprocedure surgical review. The Iowa Medicaid enterprise (IME) medical services unit conducts a preprocedure review of certain frequently performed surgical procedures to determine the necessity of the procedures and if Medicaid payment will be approved according to requirements found in 441—subrules 78.1(19), 78.3(18), and 78.26(3).

79.11(1) The physician must request approval from the IME medical services unit when the physician expects to perform a surgical procedure appearing on the department's preprocedure surgical review list published in the Medicaid provider manual. All requests for preprocedure surgical review shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid provider manual and instructions issued to providers by the IME medical services unit.

79.11(2) The IME medical services unit shall issue the physician a validation number for each request and shall advise whether payment for the procedure will be approved or denied.

79.11(3) Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, i.e., hospital or ambulatory surgical center, if the IME medical services unit does not give approval.

79.11(4) The IME medical services unit shall issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may

request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.11(5) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit in accordance with 441—Chapter 7.

79.11(6) The requirement to obtain preprocedure surgical review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the procedure has been obtained from the patient manager as described in 441—Chapter 88.

This rule is intended to implement Iowa Code section 249A.4.

441—79.12(249A) Advance directives. "Advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving medical care through the provider or organization to comply with state law regarding advance directives as follows:

79.12(1) A hospital at the time of a person's admission as an inpatient, a home health care provider in advance of a person's coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and a health maintenance organization at the time of enrollment of the person with the organization shall provide written information to each adult which explains the person's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and the provider's policies regarding the implementation of these rights.

79.12(2) The provider or organization shall document in the person's medical record whether or not the person has executed an advance directive.

79.12(3) The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.

79.12(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.12(5) The provider or organization shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this rule shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any provider or organization which as a matter of conscience cannot implement an advance directive.

This rule is intended to implement Iowa Code section 249A.4.

441—79.13(249A) Requirements for enrolled Medicaid providers supplying laboratory services. Medicaid enrolled entities providing laboratory services are subject to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, and implementing federal regulations published at 42 CFR Part 493 as amended to December 29, 2000. Medicaid payment shall not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

This rule is intended to implement Iowa Code section 249A.4.

441—79.14(249A) Provider enrollment.

79.14(1) Application request. A provider of medical or remedial services that wishes to enroll as an Iowa Medicaid provider shall begin the enrollment process by contacting the provider services unit at the Iowa Medicaid enterprise to request an application form.

a. A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

b. An intermediate care facility for persons with mental retardation shall also complete the process set forth in 441—subrule 82.3(1).

79.14(2) Submittal of application. The provider shall submit the appropriate application forms to the Iowa Medicaid enterprise provider services unit at P.O. Box 36450, Des Moines, Iowa 50315.

a. Providers of home- and community-based waiver services shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date.

b. All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.

c. The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

79.14(3) Notification. Providers shall be notified of the decision on their application by the Iowa Medicaid enterprise provider services unit within 30 calendar days.

79.14(4) Providers not approved as the type of Medicaid provider requested shall have the right to appeal under 441—Chapter 7.

79.14(5) Effective date of approval. Applications shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application forms by the Iowa Medicaid enterprise provider services unit.

79.14(6) Providers approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.14(7) No payment shall be made to a provider for care or services provided prior to the effective date of the department's approval of an application, unless the provider was enrolled and participating in the Iowa Medicaid program as of April 1, 1993.

79.14(8) Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application form, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(9) Amendments to application forms shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(10) Providers who have not submitted claims in the last 24 months will be sent a notice asking if they wish to continue participation. Providers failing to reply to the notice within 30 calendar days of the date on the notice will be terminated as providers. Providers who do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(11) Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 60 days of the change. Pertinent changes include, but are not limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, and telephone number.

a. When a provider fails to provide current information within the 60-day period, the department may terminate the provider's Medicaid enrollment upon 30 days' notice. The termination may be appealed under 441—Chapter 7.

b. When the department incurs an informational tax-reporting fine because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine shall be the responsibility of the individual provider to the extent that the fine relates to or arises out of the provider's failure to keep all provider information current.

(1) The provider shall remit the amount of the fine to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine may be appealed under 441—Chapter 7.

This rule is intended to implement Iowa Code section 249A.4.

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 Surveillance and Utilization Review Services 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.

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 Section 4201 of the ARRA, the electronic health record incentive program is governed by federal regulations at 42 CFR Part 495 as published in the Federal Register, Vol. 75, No. 144, on July 28, 2010. In compliance with the requirements of federal law, the department establishes the following state options under the Iowa electronic health record incentive program:

a. For purposes of the term "hospital-based eligible professional (EP)" as set forth in 42 CFR Section 495.4 as amended to July 28, 2010, the department elects the calendar year preceding the payment year as the period used to calculate whether or not an eligible professional is "hospital-based" for purposes of the regulation.

b. For purposes of calculating patient volume as required by 42 CFR Section 495.306 as amended to July 28, 2010, eligible providers may elect to use either:

(1) The methodology found in 42 CFR Section 495.306(c) as amended to July 28, 2010, or

(2) The methodology found in 42 CFR Section 495.306(d) as amended to July 28, 2010.

c. For purposes of 42 CFR Section 495.310(g)(1)(i)(B) as amended to July 28, 2010, the "12-month period selected by the state" shall mean the state 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 following criteria:

a. The provider must be currently enrolled as an Iowa Medicaid provider.

b. The provider must be one of the following:

(1) An eligible professional, listed as:

1. A physician,
2. A dentist,
3. A certified nurse midwife,
4. A nurse practitioner, or
5. A physician assistant practicing in a federally qualified health center or a rural health clinic when the physician assistant is the primary provider, clinical or medical director, or owner of the site.

(2) An acute care hospital, defined as a health care facility where the average length of stay is 25 days or fewer, which has a CMS certification number with the last four digits in the series 0001-0879 or 1300-1399.

(3) A children's hospital, defined as a separately certified children's hospital, either freestanding or a hospital-within-hospital, that predominately treats individuals under 21 years of age and has a CMS certification number with the last four digits in the series 3300-3399.

c. For the year for which the provider is applying for an incentive payment:

(1) An acute care hospital must have 10 percent Medicaid patient volume.

(2) An eligible professional must have at least 30 percent of the professional's patient volume covered by Medicaid, except that:

1. A pediatrician must have at least 20 percent Medicaid patient volume.
2. When a professional has at least 50 percent of patient encounters in a federally qualified health center or rural health clinic, patients who were furnished services either at no cost or at a reduced cost based on a sliding scale or ability to pay, patients covered by the HAWK-I program, and Medicaid members may be counted to meet the 30 percent threshold.

79.16(3) *Application and agreement.* Any eligible provider who wants to participate in the Iowa electronic health record incentive program must declare the intent to participate by registering with the National Level Repository, as developed by the Centers for Medicare and Medicaid Services (CMS). CMS will notify the department of an eligible provider's application for the incentive payment.

a. Upon receipt of an application for participation in the program, the department will contact the applicant with instructions for accessing the EHR incentive payment program section of the Iowa Medicaid portal access (IMPA) Web site at https://secureapp.dhs.state.ia.us/impa/. The applicant shall use the Web site to:

(1) Attest to the applicant's qualifications to receive the incentive payment, and

(2) Digitally sign Form 470-4976, Iowa Electronic Health Record Incentive Program Provider Agreement.

b. For the second year of participation, the eligible provider must submit meaningful use and clinical quality measures to the department, either through attestation or electronically as required by the department.

c. The department shall verify the applicant's eligibility, including patient volume and practice type, and the applicant's use of certified electronic health record technology.

79.16(4) *Payment.* The department shall issue the incentive payment only after confirming that all eligibility and performance criteria have been satisfied. Payments will be processed and paid to the tax identification number designated by the applicant. The department will communicate the payment or denial of payment to the National Level Repository.

a. The primary communication channel from the department to the provider will be the IMPA Web site. If the department finds that the applicant is ineligible or has failed to achieve the criteria necessary for the payment, the department shall notify the provider through the Web site. Providers shall access the Web site to determine the status of their payment, including whether the department denied payment and the reason for the denial.

b. Providers must retain records supporting their eligibility for the incentive payment for a minimum of six years. The department will select providers for audit after issuance of an incentive payment. Incentive recipients shall cooperate with the department by providing proof of:

(1) Eligibility,

(2) Purchase of certified electronic health record technology, and

(3) Meaningful use of electronic health record technology.

79.16(5) *Administrative appeal.* Any eligible provider or any provider that claims to be an eligible provider and who has been subject to an adverse action related to the Iowa electronic health record incentive program may seek review of the department's action pursuant to 441—Chapter 7. Appealable issues include:

a. Provider eligibility determination.

b. Incentive payments.

c. Demonstration of adopting, implementing, upgrading and meaningful use of technology.

This rule is intended to implement Iowa Code section 249A.4 and Public Law No. 111-5.

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1 Effective date of 79.1(2) and 79.1(5)*"t"* delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.

2 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.

TITLE XI
CHILDREN'S INSTITUTIONS

CHAPTER 101
IOWA JUVENILE HOME

[Prior to 7/1/83, Social Services[770] Ch 101]
[Prior to 2/11/87, Human Services[498]]

441—101.1(218) Definitions.

"Assigned service worker" means the individual's social work case manager who is a department employee.

"Child" means a person under the age of 18 years.

"Contraband" means weapons, ammunition, tobacco, alcohol, drugs, money, altered authorized property, mood-altering plant material, obscene material as defined in Iowa Code section 728.1(5), explosives, material that can be used in the manufacture of explosives, or material advocating disruption of or injury to residents, employees, programs, or physical facilities. "Contraband" includes anything which is illegal to possess under federal or state law and materials that are used in the production of drugs or alcohol or used in conjunction with the taking of illicit drugs. "Contraband" also includes anything determined to be banned from individual possession by published facility rules.

"Department" means the Iowa department of human services.

"Division administrator" means the administrator of the division of mental health and disability services within the department.

"Facility" means the Iowa juvenile home.

"Family" means spouse, child, parent, sibling, or grandparent.

"Gift or bequest" means anything of value that a facility receives that is intended for use directly by the employees of the facility. Items intended for public distribution, such as clothes or furniture, do not constitute a gift to the facility.

"Grievance" means a written or oral complaint by or on behalf of an individual that involves:

1. A rights violation or unfairness to the individual, or
2. Any aspect of the individual's life with which the individual does not agree.

"Individual," as used in this chapter, means any child who is committed to the director of the department of human services and is admitted to and receives services from the Iowa juvenile home. The terms "student," "resident," "juvenile," and "youth" are synonymous with the term "individual."

"Legal representative" means a person, including an attorney, who is authorized by law to act on behalf of an individual.

"Money" means all forms of currency, checks, money orders, stocks, bonds, and any other item that can be used as a medium of exchange for payment for goods or services.

"Parent" means a natural or adoptive mother or father of a child but does not include a mother or father whose parental rights have been terminated.

"Rights" means the human, civil, and constitutional liberties an individual possesses through federal and state constitutions and laws.

"Tobacco" means all forms of tobacco.

"Weapon" means any gun, knife, tool, object, or chemical that can be used to inflict harm on one's self or another.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—101.2(218) Standards.

101.2(1) The Iowa juvenile home shall comply with:

a. Standards required for comprehensive residential facilities for children in 441—Chapter 115 except that requirements contained in 441—subrule 115.4(1) for staff ratios during prime programming time are waived when there is inadequate funding.

b. Standards related to mandatory reporting of child abuse found in rule 441—112.10(232).

101.2(2) The Iowa juvenile home shall comply with the standards for group living foster care facilities in 441—Chapter 114 except that:

a. Rules 441—114.6(237) on organization and administration and 441—114.9(237) on intake procedures do not apply.

b. Only sleeping rooms built after January 1, 1988, must meet the requirements in 441—paragraph 114.3(2)*"b."*

c. Staff job descriptions shall be identified by the department of administrative services' human resources enterprise.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—101.3(218) Admission.

101.3(1) *Population guidelines.* The facility population level shall be based on the population guidelines that the judicial branch, in consultation with the department, develops on the number of individuals who may be placed at a juvenile facility at any one time. Pursuant to those guidelines and the responsibility of the superintendent for admission of individuals, the superintendent and the chief juvenile court officers shall allocate to each judicial district the number of children from each district who may be placed in the facility for diagnosis and evaluation and for treatment.

101.3(2) *Acceptance of child.* A certified copy of the court order which complies with Iowa Code chapter 232 shall accompany the child to the facility, along with the relevant petitions.

a. A child shall be accepted for evaluation as specified in the court order only when a diagnostic bed is available.

b. A child shall be accepted into the regular program as specified in the court order only when a treatment bed is available.

c. A child adjudicated to have committed a delinquent act shall not be admitted to the Iowa juvenile home.

d. The superintendent or chief juvenile court officer shall notify the court when the appropriate space, service, or program is not available so that admission can be ordered when the facility can meet the child's needs.

101.3(3) *Time of admission.* When a child is to be admitted to the Iowa juvenile home, arrangements shall be made for the actual admission to occur between 8 a.m. and 4:30 p.m., Monday through Friday, whenever possible.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—101.4(218) Plan of care.

101.4(1) *Individual care plan conference.* At least ten working days before the individual care plan conference, the facility shall provide written notification of the time, date and nature of the conference to:

a. The individual;

b. The individual's parents;

c. The individual's legal representative;

d. The assigned service worker; and

e. The court.

101.4(2) *Special meeting.* Whenever special concerns and needs arise regarding an individual, the superintendent or designee shall schedule a meeting to evaluate and formulate appropriate changes in the individual care plan. Notice of the meeting shall be issued to:

a. The individual;

b. The individual's parents;

c. The individual's legal representative;

d. The assigned service worker; and

e. Other relevant parties.

101.4(3) *Prerelease conference.* A conference shall be held 30 days before any anticipated release of an individual from the regular program. At least 5 working days before the conference, the facility shall provide written notice of the time, date, and purpose of the conference to:

a. The individual;

b. The individual's parents;

c. The individual's legal representative;

d. The assigned service worker; and

e. The court.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—101.5(218) Communication with individuals.

101.5(1) *Incoming telephone calls.* Approval of the superintendent or designee is required for all incoming telephone calls for an individual before the conversation occurs. An authorized employee shall verify the identity of the caller before approval is given. Approved telephone calls shall not be monitored.

101.5(2) *Mail and packages.*

a. Outgoing or incoming letters and packages shall not be opened, read, censored, or tampered with in any manner except that, to search for and seize contraband, an employee may:

(1) Open, but not read, incoming and outgoing letters and packages in the presence of the individual to whom the letters and packages belong; or

(2) Require that the individual open the letters and packages in an employee's presence and disclose the contents.

b. Letters or packages found to contain contraband shall be confiscated. Both the sender and the intended receiver of the confiscated letters and packages shall be notified and given reasons for the action in writing within 48 hours of the action.

c. The superintendent or designee may terminate correspondence between an individual and another person when the individual's treatment team has determined that the correspondence is not in the individual's best interest and is detrimental to the individual's treatment plan. Termination shall be based on the circumstances of each case.

(1) The superintendent or designee shall provide justification to terminate the correspondence in a written notice to the correspondents.

(2) Correspondents may file a grievance concerning the termination.

101.5(3) *Visits.*

a. Schedule. Visiting hours shall be from 10 a.m. to 4:30 p.m. on Saturday and Sunday. Visits by the individual's family or legal representative shall be encouraged. Necessary flexibility in these hours and days will be allowed.

(1) The superintendent may designate certain weekdays or holidays for visiting. The resident shall be responsible for informing visitors about designated visiting days.

(2) Visiting during times other than those described in this subrule shall require approval of the superintendent before the day of the visit.

b. Applicability. Other than a family member or legal representative, a person who wants to visit an individual shall obtain prior approval from the superintendent or designee before visiting. Visitation rights shall be denied to:

(1) A former juvenile home resident unless the former resident is a family member or has prior approval of the superintendent or designee;

(2) A parent whose parental rights have been terminated or limited by court order;

(3) A person who is restricted by court order from contact with the individual;

(4) A visitor who refuses to cooperate with the rules of the facility;

(5) A visitor who creates a disturbance or is hostile to the point of being disruptive;

(6) A visitor who passes or attempts to pass contraband to an individual or who aids in an escape or attempted escape;

(7) A visitor who is under the influence of or has been partaking of drugs or alcoholic beverages; and

(8) Any other person who, based on reasonable cause, is believed to pose a risk to the individual's treatment or to the safety or security of the facility.

c. Procedures.

(1) Visitors shall check in with security upon arrival. The employee on duty may request identification of the visitor. Failure to produce identification may result in denial of the visit.

(2) An individual shall be permitted to visit with up to six family members during any one visit. Family members under 18 years of age shall visit only with adult family supervision.

(3) An individual shall not be permitted to visit with the family of another individual unless the superintendent or designee has given prior approval. An individual shall have written authorization of the superintendent or designee before accompanying parents of another individual off grounds on a visit.

d. Limits. The superintendent reserves the right to limit or terminate visiting in all cases when doing so is in the best interests of the individual's personal and therapeutic needs. When limitation or termination of visiting rights occurs, the superintendent or designee shall:

(1) Immediately notify persons involved why the action was taken; and

(2) Place a written report in the individual's file.

101.5(4) *Attorney contacts.* An individual's attorney shall have the right to visit or have telephone contact with the individual at any reasonable time.

a. An individual shall have the right to contact the individual's attorney during normal business hours and at other times with prior approval of the attorney. Responsibility for payment for the cost of the contact shall be determined before the contact is made.

b. An individual who does not have an attorney shall be referred to the committing court for an attorney to be appointed.

101.5(5) *Interviews and statements.*

a. Request. Requests to interview an individual made by media (newspapers, television stations, radio stations, etc.), groups, or persons not related to the individual shall be made through the superintendent's office.

(1) The superintendent or designee shall inform the individual of the request and of the individual's right to agree to participate in the interview or to remain silent and not participate.

(2) If an interview may have an impact on the individual's legal status, the superintendent or designee shall contact the individual's attorney to determine if the attorney has any objection to the individual's participation.

b. Decision. When the individual agrees to participate, the interview shall be granted at the discretion of the superintendent. The superintendent may deny an interview in situations deemed detrimental to the individual. The person requesting the interview may appeal the superintendent's decision to the division administrator.

c. Procedure.

(1) Whenever an interview is granted, at least one facility employee shall be present for the entirety of the interview and shall have the authority to terminate the interview anytime the employee believes the best interests of the individual are not being served. Exceptions to this requirement shall be made when the individual's interview is with the individual's own attorney or with state officials acting in an official capacity.

(2) The individual shall be represented by legal counsel during any interview that is conducted to obtain information that will be or may be used in court.

d. Depositions. The superintendent may grant permission for written depositions according to the procedures for granting interviews. Voice recording of depositions shall not be permitted. One copy of the deposition shall be submitted to the superintendent. This rule shall in no way restrict depositions ordered by the court.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—101.6(218) Photographing and recording of individuals. An individual's parent or legal representative may take photographs or make audio or video recordings of that individual but shall not be authorized to take photographs or make recordings of any other individual.

101.6(1) With the authorization of the superintendent or designee, an individual may take a photograph of another individual with that individual's consent.

101.6(2) Use of still or video cameras or voice recorders to photograph or record an individual by anyone other than the individual, parent, legal representative or authorized employee shall be allowed only with the prior authorization of the superintendent or designee.

a. When granted, authorization to photograph or record shall be for one specific use and shall not extend to any other use.

b. Photographs and video or voice recordings of an individual for public distribution shall be permitted only with a signed informed consent from the superintendent and the individual's parent or legal representative.

101.6(3) A person authorized to take photographs or recordings shall make every effort to preserve the inherent dignity of the individual and to preclude exploitation or embarrassment of the individual or the family of the individual.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—101.7(218) Employment of individual. Employers that want to hire an individual must obtain approval from the superintendent or designee.

101.7(1) To clarify the employer-individual employment agreement, the superintendent or designee shall communicate to the individual's employer and document:

a. The employer's legal responsibilities, including:

(1) Adherence to child labor laws; and

(2) Payment in accordance with the Fair Labor Standards Act. Work of a more skilled nature shall be compensated accordingly.

b. The employer's responsibility to meet the requirements of the Iowa juvenile home, including but not limited to those relating to salary, supervision, transportation, and work hours of the individual. The employer shall:

(1) Make all payments for the individual's employment to the facility business office for deposit in the individual's account. Payment of any nature shall not be given directly to the individual for any purpose.

(2) Immediately report a runaway individual to the superintendent or designee.

(3) Report to the superintendent or designee an individual's behavior that is unacceptable to the employer.

101.7(2) An individual's behavior that is unacceptable to an employer shall not subject the individual to any sanctions, punishment or punitive restriction of privileges unless the behavior constitutes a public offense or violates facility rules. In such case, the individual may be referred to court for prosecution or the facility's discipline procedure may be followed.

101.7(3) The employer, the superintendent or designee, or the individual shall have the right to terminate the employment at any time.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—101.8(218) Temporary home visits.

101.8(1) An individual may be granted a temporary home visit for up to five days for reasons such as:

a. To attend funerals, weddings, or holiday functions;

b. For job seeking;

c. For the primary purpose of exploring and improving family and community relations; or

d. For a preplacement visit to a foster or group home to test the appropriateness of such a placement.

101.8(2) The superintendent or designee and the assigned service worker shall approve a temporary home visit before the visit is scheduled and only after the assigned service worker has investigated and approved in writing the temporary home visit placement.

101.8(3) Five working days in advance of a visit, the superintendent or designee shall notify the following in writing:

a. The individual's parents;

b. The individual's legal representative;

c. The temporary placement, if different from the parents' home;

d. The assigned service worker; and

e. The court.

101.8(4) In cases of an emergency, the notice required by subrule 101.8(3) may be delivered by telephone and shall be followed by a written notice explaining the special circumstance.

101.8(5) In a special case, based on the individual's treatment needs, the superintendent or designee may extend a temporary home visit when both the superintendent or designee and the assigned service worker's supervisor agree that the proposed extension is appropriate.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—101.9(218) Grievances. Any individual who believes the individual's rights have been violated by the Iowa juvenile home or who has a complaint concerning the individual's treatment at the Iowa juvenile home may file a grievance. The individual's parent, family, or legal representative may file a grievance on behalf of the individual by submitting the grievance in writing to the superintendent.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—101.10(218) Alleged child abuse. The department shall arrange for the investigation of any reported case of alleged child abuse. For cases in which the alleged perpetrator is a facility employee, contractor, or volunteer, or some other department employee, the investigation shall be conducted by an agency other than the department.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—101.11(233B) Cost of care. The Iowa juvenile home shall seek to recover a portion of the cost of care from an individual who has unearned income. In determining the amount to be recovered:

1. The individual shall be allowed to retain a personal allowance equal to the personal allowance amount established by the Social Security Administration for the Supplemental Security Income program.

2. The amount recovered shall not exceed the actual cost of care.

3. The cost of care shall be determined using the average per diem multiplied by the total days of care.

4. The superintendent may grant a one-time exception to recovery of up to $1,000 for a personal needs living expense if an individual is being discharged and has no viable means of support upon release.

This rule is intended to implement Iowa Code section 233B.16.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—101.12(218) Buildings and grounds.

101.12(1) *Tours.* Tours of the facility shall be subject to the prior approval of the superintendent or designee. Tours may be scheduled on weekdays from 8 a.m. to 4 p.m. by appointment through the superintendent's office. Approval shall be based on availability of employee time to conduct the tour and the programmatic and security needs of the facility.

101.12(2) *Public use.* Facility space shall be for the primary use of the Iowa juvenile home. All public use of facility space shall require prior approval of the superintendent or designee. Approval for

use shall be based on the order of requests received and on space availability after the programmatic and security needs of the facility are met.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—101.13(8,218) Gifts and bequests. Gifts or bequests of money, clothing, books, games, recreational equipment or other gifts shall be made directly to the superintendent.

101.13(1) The superintendent or designee shall evaluate the gift or bequest in terms of the nature of the contribution to the facility program.

101.13(2) The superintendent shall be responsible for accepting the gift or bequest and reporting it to the division administrator.

a. All monetary gifts or bequests shall be acknowledged in writing to the donor.

b. All gifts or bequests, regardless of value, shall be reported to the Iowa ethics and campaign disclosure board within 20 days of receipt of the gift or bequest using the board's Form-GB.

This rule is intended to implement Iowa Code sections 8.7 and 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

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CHAPTER 103
STATE TRAINING SCHOOL

[Prior to 7/1/83, Social Services[770] Ch 103]
[Prior to 2/11/87, Human Services[498]]

441—103.1(218) Definitions.

"Child" means a person under the age of 18 years.

"Contraband" means weapons, ammunition, tobacco, alcohol, drugs, money, altered authorized property, mood-altering plant material, obscene material as defined in Iowa Code section 728.1(5), explosives, material that can be used in the manufacture of explosives, or material advocating disruption of or injury to residents, employees, programs, or physical facilities. "Contraband" includes anything which is illegal to possess under federal or state law and materials that are used in the production of drugs or alcohol or used in conjunction with the taking of illicit drugs. "Contraband" also includes anything determined to be banned from individual possession by published facility rules.

"Department" means the Iowa department of human services.

"Division administrator" means the administrator of the division of mental health and disability services within the department.

"Facility" means the state training school.

"Family" means spouse, child, parent, sibling, or grandparent.

"Gift or bequest" means anything of value that a facility receives that is intended for use directly by the employees of the facility. Items intended for public distribution, such as clothes or furniture, do not constitute a gift to the facility.

"Grievance" means a written or oral complaint by or on behalf of an individual that involves:

1. A rights violation or unfairness to the individual, or
2. Any aspect of the individual's life with which the individual does not agree.

"Individual," as used in this chapter, means any child who is committed to the director of the department of human services and is admitted to and receives services from the state training school. The terms "student," "resident," "juvenile," and "youth" are synonymous with the term "individual." For purposes of the state training school, the term shall also include a person whose stay is extended beyond the age of 18 under the provisions of 2009 Iowa Code Supplement sections 232.53(2) and 232.53(4).

"Iowa sex offender registry" means a central registry of sex offenders established under 2009 Iowa Code Supplement chapter 692A that is maintained by the department of public safety.

"Juvenile court officer" means the same as defined in Iowa Code section 232.2(30).

"Juvenile offender" means a juvenile who is required to be registered with the Iowa sex offender registry and with the sheriff of the juvenile's county of residence.

"Legal representative" means a person, including an attorney, who is authorized by law to act on behalf of an individual.

"Money" means all forms of currency, checks, money orders, stocks, bonds, and any other item that can be used as a medium of exchange for payment for goods or services.

"Parent" means a natural or adoptive mother or father of a child but does not include a mother or father whose parental rights have been terminated.

"Registration" means the submission of registration forms to the Iowa sex offender registry and to the sheriff of the person's county of residence.

"Rights" means the human, civil, and constitutional liberties an individual possesses through federal and state constitutions and laws.

"State training school" means the units for juvenile delinquents at the Eldora and Toledo facilities as defined in Iowa Code section 233A.1(2).

"Tobacco" means all forms of tobacco.

"Weapon" means any gun, knife, tool, object, or chemical that can be used to inflict harm on one's self or another.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—103.2(218) Admission.

103.2(1) *Population guidelines.* The facility population level shall be based on the population guidelines that the judicial branch, in consultation with the department, develops on the number of individuals who may be placed at a juvenile facility at any one time. Pursuant to those guidelines and the responsibility of the superintendents for admission of individuals, the superintendents and the chief juvenile court officers shall allocate to each judicial district the number of children from each district who may be placed in the facility for diagnosis and evaluation and for treatment.

103.2(2) *Acceptance of child.* A certified copy of the court order which complies with Iowa Code chapter 232 shall accompany the child to the facility, along with the relevant petitions.

a. A child shall be accepted for evaluation as specified in the court order only when a diagnostic bed is available.

b. A child shall be accepted into the regular program as specified in the court order only when a treatment bed is available.

c. A child adjudicated as a child in need of assistance shall not be admitted to the state training school, except:

(1) For diagnosis and evaluation and then only when a current petition is on file that alleges the child to have committed a delinquent act, or

(2) When the child is also adjudicated delinquent and meets admission criteria for the state training school as a delinquent.

d. The superintendent or chief juvenile court officer shall notify the court when the appropriate space, service, or program is not available so that admission can be ordered when the facility can meet the child's needs.

103.2(3) *Time of admission.* When a child is to be admitted to the state training school, arrangements shall be made for the actual admission to occur between 8 a.m. and 4:30 p.m., Monday through Friday, whenever possible.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—103.3(218) Plan of care.

103.3(1) *Individual care plan conference.* At least ten working days before the individual care plan conference, the facility shall provide written notification of the time, date and nature of the conference to:

a. The individual;

b. The individual's parents;

c. The individual's legal representative;

d. The individual's juvenile court officer; and

e. The court.

103.3(2) *Special meeting.* Whenever special concerns and needs arise regarding an individual, the superintendent or designee shall schedule a meeting to evaluate and formulate appropriate changes in the individual care plan. Notice of the meeting shall be issued to:

a. The individual;

b. The individual's parents;

c. The individual's legal representative;

d. The individual's juvenile court officer; and

e. Other relevant parties.

103.3(3) *Prerelease conference.* A conference shall be held 30 days before any anticipated release of an individual from the regular program. At least 5 working days before the conference, the facility shall provide written notice of the time, date, and purpose of the conference to:

a. The individual;

b. The individual's parents;

c. The individual's legal representative;

d. The individual's juvenile court officer; and

e. The court.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—103.4(218) Communication with individuals.

103.4(1) *Incoming telephone calls.* Approval of the superintendent or designee is required for all incoming telephone calls for an individual before the conversation occurs. An authorized employee shall verify the identity of the caller before approval is given. Approved telephone calls shall not be monitored.

103.4(2) *Mail and packages.*

a. Outgoing or incoming letters and packages shall not be opened, read, censored, or tampered with in any manner except that, to search for and seize contraband, an employee may:

(1) Open, but not read, incoming and outgoing letters and packages in the presence of the individual to whom the letters and packages belong; or

(2) Require that the individual open the letters and packages in an employee's presence and disclose the contents.

b. Letters or packages found to contain contraband shall be confiscated. Both the sender and the intended receiver of the confiscated letters and packages shall be notified and given reasons for the action in writing within 48 hours of the action.

c. The superintendent or designee may terminate correspondence between an individual and another person when the individual's treatment team has determined that the correspondence is not in the individual's best interest and is detrimental to the individual's treatment plan. Termination shall be based on the circumstances of each case.

(1) The superintendent or designee shall provide justification to terminate the correspondence in a written notice to the correspondents.

(2) Correspondents may file a grievance concerning the termination.

103.4(3) *Visits.*

a. Schedule. Visiting hours shall be from 10 a.m. to 4:30 p.m. on Saturday and Sunday. Visits by the individual's family or legal representative shall be encouraged. Necessary flexibility in these hours and days will be allowed.

(1) The superintendent may designate certain weekdays or holidays for visiting. The resident shall be responsible for informing visitors about designated visiting days.

(2) Visiting during times other than those described in this subrule shall require approval of the superintendent before the day of the visit.

b. Applicability. Other than a family member or legal representative, a person who wants to visit an individual shall obtain prior approval from the individual's juvenile court officer and the superintendent or designee before visiting. Visitation rights shall be denied to:

(1) A former training school resident unless the former resident is a family member or has prior approval of the superintendent or designee;

(2) A parent whose parental rights have been terminated or limited by court order;

(3) A person who is restricted by court order from contact with the individual;

(4) A visitor who refuses to cooperate with the rules of the facility;

(5) A visitor who creates a disturbance or is hostile to the point of being disruptive;

(6) A visitor who passes or attempts to pass contraband to an individual or who aids in an escape or attempted escape;

(7) A visitor who is under the influence of or has been partaking of drugs or alcoholic beverages; and

(8) Any other person who, based on reasonable cause, is believed to pose a risk to the individual's treatment or to the safety or security of the facility.

c. Procedures.

(1) Visitors shall check in with security upon arrival. The employee on duty may request identification of the visitor. Failure to produce identification may result in denial of the visit.

(2) An individual shall be permitted to visit with up to six family members during any one visit. Family members under 18 years of age shall visit only with adult family supervision.

(3) An individual shall not be permitted to visit with the family of another individual unless the individual's juvenile court officer and the superintendent or designee have given prior approval. An individual shall have written authorization of the individual's juvenile court officer and the superintendent or designee before accompanying parents of another individual off grounds on a visit.

d. Limits. The superintendent reserves the right to limit or terminate visiting in all cases when doing so is in the best interests of the individual's personal and therapeutic needs. When limitation or termination of visiting rights occurs, the superintendent or designee shall:

(1) Immediately notify persons involved why the action was taken; and

(2) Place a written report in the individual's file.

103.4(4) *Attorney contacts.* An individual's attorney shall have the right to visit or have telephone contact with the individual at any reasonable time.

a. An individual shall have the right to contact the individual's attorney during normal business hours and at other times with prior approval of the attorney. Responsibility for payment for the cost of the contact shall be determined before the contact is made.

b. An individual who does not have an attorney shall be referred to the committing court for an attorney to be appointed.

103.4(5) *Interviews and statements.*

a. Request. Requests to interview an individual made by media (newspapers, television stations, radio stations, etc.), groups, or persons not related to the individual shall be made through the superintendent's office.

(1) The superintendent or designee shall inform the individual of the request and of the individual's right to agree to participate in the interview or to remain silent and not participate.

(2) If an interview may have an impact on the individual's legal status, the superintendent or designee shall contact the individual's attorney to determine if the attorney has any objection to the individual's participation.

b. Decision. When the individual agrees to participate, the interview shall be granted at the discretion of the superintendent. The superintendent may deny an interview in situations deemed detrimental to the individual. The person requesting the interview may appeal the superintendent's decision to the division administrator.

c. Procedure.

(1) Whenever an interview is granted, at least one facility employee shall be present for the entirety of the interview and shall have the authority to terminate the interview anytime the employee believes the best interests of the individual are not being served. Exceptions to this requirement shall be made when the individual's interview is with the individual's own attorney or with state officials acting in an official capacity.

(2) The individual shall be represented by legal counsel during any interview that is conducted to obtain information that will be or may be used in court.

d. Depositions. The superintendent may grant permission for written depositions according to the procedures for granting interviews. Voice recording of depositions shall not be permitted. One copy of the deposition shall be submitted to the superintendent. This rule shall in no way restrict depositions ordered by the court.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—103.5(218) Photographing and recording of individuals. An individual's parent or legal representative may take photographs or make audio or video recordings of that individual but shall not be authorized to take photographs or make recordings of any other individual.

103.5(1) With the authorization of the superintendent or designee, an individual may take a photograph of another individual with that individual's consent.

103.5(2) Use of still or video cameras or voice recorders to photograph or record an individual by anyone other than the individual, parent, legal representative, or authorized employee shall be allowed only with the prior authorization of the superintendent or designee.

a. When granted, authorization to photograph or record shall be for one specific use and shall not extend to any other use.

b. Photographs and voice or video recordings of an individual for public distribution shall be permitted only with a signed informed consent from the superintendent and the individual's parent or legal representative.

103.5(3) A person authorized to take photographs or recordings shall make every effort to preserve the inherent dignity of the individual and to preclude exploitation or embarrassment of the individual or the family of the individual.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—103.6(218) Employment of individual. Employers that want to hire an individual must obtain approval from the superintendent or designee.

103.6(1) To clarify the employer-individual employment agreement, the superintendent or designee shall communicate to the individual's employer and document:

a. The employer's legal responsibilities, including:

(1) Adherence to child labor laws; and

(2) Payment in accordance with the Fair Labor Standards Act. Work of a more skilled nature shall be compensated accordingly.

b. The employer's responsibility to meet the requirements of the training school, including but not limited to those relating to salary, supervision, transportation, and work hours of the individual. The employer shall:

(1) Make all payments for the individual's employment to the facility business office for deposit in the individual's account. Payment of any nature shall not be given directly to the individual for any purpose.

(2) Immediately report a runaway individual to the superintendent or designee.

(3) Report to the superintendent or designee an individual's behavior that is unacceptable to the employer.

103.6(2) An individual's behavior that is unacceptable to an employer shall not subject the individual to any sanctions, punishment or punitive restriction of privileges unless the behavior constitutes a public offense or violates facility rules. In such case, the individual may be referred to court for prosecution or the facility's discipline procedure may be followed.

103.6(3) The employer, the superintendent or designee, or the individual shall have the right to terminate the employment at any time.

This rule is intended to implement Iowa Code section 218.4.

[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—103.7(218) Temporary home visits.

103.7(1) An individual may be granted a temporary home visit for up to five days for reasons such as:

a. To attend funerals, weddings, or holiday functions;

b. For job seeking;

c. For the primary purpose of exploring and improving family and community relations; or

d. For a preplacement visit to a foster or group home to test the appropriateness of such a placement.

103.7(2) The superintendent or designee and the individual's juvenile court officer shall approve a temporary home visit before the visit is scheduled and only after the juvenile court officer has investigated and approved in writing the temporary home visit placement.

103.7(3) Five working days in advance of a visit, the superintendent or designee shall notify the following in writing:

a. The individual's parents;
b. The individual's legal representative;
c. The temporary placement, if different from the parents' home;
d. The individual's juvenile court officer; and
e. The court.

103.7(4) In cases of an emergency, the notice required by subrule 103.7(3) may be delivered by telephone and shall be followed by a written notice explaining the special circumstance.

103.7(5) In a special case, based on the individual's treatment needs, the superintendent or designee may extend a temporary home visit when both the superintendent or designee and the individual's juvenile court officer agree that the proposed extension is appropriate.

This rule is intended to implement Iowa Code section 218.4.
[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—103.8(218) Grievances. Any individual who believes the individual's rights have been violated by the state training school or who has a complaint concerning the individual's treatment at the state training school may file a grievance. The individual's parent, family, or legal representative may file a grievance on behalf of the individual by submitting the grievance in writing to the superintendent.

This rule is intended to implement Iowa Code section 218.4.
[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—103.9(692A) Sex offender registration. An individual who has been determined to be a sex offender as defined in 2009 Iowa Code Supplement section 692A.101 must register as a sex offender before release from the state training school unless the juvenile court finds that the individual is exempted from this requirement.

103.9(1) *Notification.* When an individual who is a juvenile offender has not previously registered, the superintendent or designee shall provide the individual with Form DCI-144, Notification of Registration Requirement, as required by the department of public safety in 661—subrule 83.3(1). Failure to provide a juvenile offender with the notification form does not relieve the juvenile offender of the duty to register with the Iowa sex offender registry.

103.9(2) *Exemption from registration.* To exempt a juvenile offender from registration, the language in the order of adjudication or disposition must clearly state that the juvenile offender is exempted from the registration requirement. If a court order is silent, the registration requirement applies.

a. If the order language does not clearly state that the juvenile offender is exempted from the registration process, then the responsibility rests with the juvenile offender to seek a clarifying order to be exempt from the registration process. A juvenile offender who seeks an exemption from the registration requirement has the obligation to prove that the juvenile offender deserves the exemption.

b. When the judicial decision is deferred, registration shall be assumed to be required until the court orders otherwise. If the court order defers the decision to grant an exemption from registration until the juvenile offender's treatment is completed, the language in the order should specify who tracks the case until the new court order is issued. If it is not clear who tracks the case, the juvenile offender is responsible to seek a clarifying order to be exempt from the registration process.

103.9(3) *Registration.* The superintendent or designee shall provide the juvenile offender with Form DCI-145, Sex Offender Registration, as required by the department of public safety in 661—subrule 83.3(2). Form DCI-145 must be submitted to the sheriff of each county in which the offender will be residing, employed, or attending classes as well as to the department of public safety to satisfy the registration requirements of the Iowa sex offender registry.

a. When the juvenile offender is released from the state training school, the superintendent or designee shall submit the registration form to the division of criminal investigation of the department of public safety unless, by the time of release, the juvenile court finds that the juvenile should not be required to register as allowed by 2009 Iowa Code Supplement chapter 692A.

b. Copies of the sex offender registration shall be maintained in the juvenile offender's file at the state training school.

This rule is intended to implement 2009 Iowa Code Supplement section 692A.109.
[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—103.10(218) Alleged child abuse. The department shall arrange for the investigation of any reported case of alleged child abuse. For cases in which the alleged perpetrator is a facility employee, contractor, or volunteer, or some other department employee, the investigation shall be conducted by an agency other than the department.

This rule is intended to implement Iowa Code section 218.4.
[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—103.11(233A) Cost of care. The state training school shall seek to recover a portion of the cost of care from an individual who has unearned income. In determining the amount to be recovered:

1. The individual shall be allowed to retain a personal allowance equal to the personal allowance amount established by the Social Security Administration for the Supplemental Security Income program.
2. The amount recovered shall not exceed the actual cost of care.
3. The cost of care shall be determined using the average per diem multiplied by the total days of care.
4. The superintendent may grant a one-time exception to recovery of up to $1,000 for a personal needs living expense if an individual is being discharged and has no viable means of support upon release.

This rule is intended to implement Iowa Code section 233A.17.
[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—103.12(218) Buildings and grounds.

103.12(1) *Tours.* Tours of the facility shall be subject to the prior approval of the superintendent or designee. Tours may be scheduled on weekdays from 8 a.m. to 4 p.m. by appointment through the superintendent's office. Approval shall be based on availability of employee time to conduct the tour and the programmatic and security needs of the facility.

103.12(2) *Public use.* Facility space shall be for the primary use of the state training school. All public use of facility space shall require prior approval of the superintendent or designee. Approval for use shall be based on the order of requests received and on space availability after the programmatic and security needs of the facility are met.

This rule is intended to implement Iowa Code section 218.4.
[**ARC 9318B**, IAB 12/29/10, effective 2/2/11]

441—103.13(8,218) Gifts and bequests. Gifts or bequests of money, clothing, books, games, recreational equipment or other gifts shall be made directly to the superintendent.

103.13(1) The superintendent or designee shall evaluate the gift or bequest in terms of the nature of the contribution to the facility program.

103.13(2) The superintendent shall be responsible for accepting the gift or bequest and reporting it to the division administrator.

a. All monetary gifts or bequests shall be acknowledged in writing to the donor.

b. All gifts or bequests, regardless of value, shall be reported to the Iowa ethics and campaign disclosure board within 20 days of receipt of the gift or bequest using the board's Form-GB. One copy of the completed form shall be sent to the division administrator.

This rule is intended to implement Iowa Code sections 8.7 and 218.4.
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481—11.1(17A,724) Definitions.

"Agency" means the commissioner of public safety or the sheriff of the county in which the aggrieved party resides.

"Applicant" means a person who has applied for a permit to carry weapons or acquire firearms.

"Contested case" means a proceeding defined by Iowa Code section 17A.2(5).

"Division" means the division of administrative hearings of the Iowa department of inspections and appeals.

"Party" means each person or agency named or admitted as a party.

"Permittee" means a person who has received a permit to carry weapons or acquire firearms.

[**ARC 9299B**, IAB 12/29/10, effective 1/1/11]

481—11.2(724) Appeals. An applicant or permittee may appeal a decision by an agency to deny an application for a permit to carry weapons or acquire firearms or to suspend or revoke a permit to carry weapons or acquire firearms.

11.2(1) *Written appeal.* The appeal shall be in writing and clearly state the reasons for rebutting the denial, suspension, or revocation.

11.2(2) *Filing of appeal.* Within 30 days of the applicant's or permittee's receipt of the agency's decision, the applicant or permittee shall file the appeal, a copy of the agency's written decision, and a fee of $10 with the Iowa Department of Inspections and Appeals, Division of Administrative Hearings, 502 East 9th Street, Des Moines, Iowa 50319.

11.2(3) *Service on the agency.* The applicant or permittee shall serve a copy of the appeal on the agency at the time the appeal is filed with the division.

11.2(4) *Denial of appeal.* The division may deny any appeal that does not meet each of the requirements in subrules 11.2(1) to 11.2(3).

[**ARC 9299B**, IAB 12/29/10, effective 1/1/11]

481—11.3(17A,724) Notice of hearing. The division shall prepare and serve the notice of hearing.

11.3(1) The notice of hearing shall contain the following information:

a. A statement of the time, place, and nature of the hearing;

b. A statement of the legal authority and jurisdiction under which the hearing is to be held;

c. A reference to the agency decision on appeal;

d. Identification of the parties;

e. Reference to the procedural rules governing the contested case proceeding;

f. Identification of the administrative law judge, including the judge's address and telephone number; and

g. Notification that failure to appear and participate in the contested case proceeding may result in the entry of a default judgment.

11.3(2) Service of the notice of hearing shall be accomplished by first-class mail.

[**ARC 9299B**, IAB 12/29/10, effective 1/1/11]

481—11.4(17A,724) Agency record.

11.4(1) Upon receipt of a copy of the notice of hearing, the agency shall file with the division:

a. A copy of all documents used by the agency in reaching the decision; and

b. A form identifying the name, address, and telephone number of the agency's contact person or attorney representative.

11.4(2) The agency shall provide to the applicant or permittee a copy of all documents used by the agency in reaching the decision.

[**ARC 9299B**, IAB 12/29/10, effective 1/1/11]

481—11.5(17A) Contested case hearing. The hearing shall be conducted pursuant to the standards established in Iowa Code chapter 17A for contested case hearings. The hearing shall be held by telephone conference call, unless a party to the proceeding requests an in-person hearing from the administrative law judge no later than five days before the hearing. All in-person hearings shall be held at the division's headquarters in Des Moines, Iowa. If the administrative law judge grants an in-person hearing, the administrative law judge may allow one party to appear by telephone.
[**ARC 9299B**, IAB 12/29/10, effective 1/1/11]

481—11.6(17A) Service and filing of documents.

11.6(1) *When service is required.* Every document filed in a contested case proceeding shall be served on each party of record. Service shall be made by delivering or mailing a copy to the party's last-known address.

11.6(2) *Filing.* All documents in the contested case proceeding shall be filed with the administrative law judge. A document is deemed filed at the time it is received by the division. A document is deemed to be served when mailed by first-class mail, so long as there is proof of mailing.

11.6(3) *Proof of mailing.* Proof of mailing includes a legible United States Postal Service postmark on the envelope and a certificate of service, a notarized affidavit, or certification in substantially the following form:

> I certify under penalty of perjury and pursuant to the laws of the state of Iowa, that on (date of mailing or hand-delivery), I mailed or hand-delivered copies (describe document(s)) addressed to (opposing party) by depositing the same in a United States post office mailbox with correct postage properly affixed, or I hand-delivered copies.
> (Date) (Signature)

11.6(4) *Filing by electronic means.* The administrative law judge may permit service or filing of particular documents by facsimile, electronic mail, or similar electronic means. When permitted, service by facsimile, electronic mail, or similar electronic means is complete upon transmission.
[**ARC 9299B**, IAB 12/29/10, effective 1/1/11]

481—11.7(17A) Witness lists and exhibits. No later than five days before the hearing, a party shall serve on all parties and the administrative law judge a witness list and a copy of any exhibit(s) the party intends to introduce into evidence during the contested case proceeding. If a party fails to serve on all parties and the administrative law judge a witness list or any exhibit five days before the hearing, the party may be precluded from calling the witness at hearing or introducing the exhibit(s) into the record at hearing.
[**ARC 9299B**, IAB 12/29/10, effective 1/1/11]

481—11.8(17A) Evidence. The administrative law judge shall rule on the admissibility of evidence and may take official notice of facts in accordance with applicable requirements of law. Evidence in the proceeding shall be confined to the issues for which the parties received notice prior to the hearing.
[**ARC 9299B**, IAB 12/29/10, effective 1/1/11]

481—11.9(17A) Withdrawals and dismissals. A request for withdrawal or dismissal of the appeal may be made with the division prior to the hearing. Either request must be in writing or secured on the record.

11.9(1) *Withdrawals.* An applicant or permittee who requested a contested case proceeding may request a withdrawal of the appeal. Upon receipt of a request for withdrawal of the appeal, the administrative law judge shall issue an order dismissing the appeal and closing the case.

11.9(2) *Dismissals.* An agency may request a dismissal of the appeal by agreeing to grant the entire relief sought by the applicant or permittee. The administrative law judge shall review a request for dismissal to determine whether it grants all relief requested in the appeal. If the request grants all relief requested in the appeal, the administrative law judge shall issue an order dismissing the appeal, ordering the agency to grant the relief requested, and closing the case.
[**ARC 9299B**, IAB 12/29/10, effective 1/1/11]

481—11.10(17A) Default. If a party fails to appear after proper service of notice, the administrative law judge may enter a default order against the party or may proceed with the hearing and make a decision in the absence of the party.
[**ARC 9299B**, IAB 12/29/10, effective 1/1/11]

481—11.11(10A) Costs. Costs of the contested case hearing shall be paid by the agency.
[**ARC 9299B**, IAB 12/29/10, effective 1/1/11]

481—11.12(724) Probable cause. Probable cause to deny an initial or renewal application for a permit to carry weapons or acquire firearms or to suspend or revoke a permit to carry weapons or acquire firearms means a reasonable ground exists for supposing that the basis for the denial, suspension or revocation is well-founded.
[**ARC 9299B**, IAB 12/29/10, effective 1/1/11]

481—11.13(724) Clear and convincing evidence. Clear and convincing evidence means there is no serious or substantial doubt about the correctness of the conclusion drawn from the evidence.
[**ARC 9299B**, IAB 12/29/10, effective 1/1/11]

These rules are intended to implement 2010 Iowa Acts, Senate File 2379, section 14.

[Filed Emergency ARC 9299B, IAB 12/29/10, effective 1/1/11]

AUDITS DIVISION

CHAPTERS 12 to 21
Reserved

STATE PUBLIC DEFENDER[493]

Created within the Department of Inspections and Appeals[481] by Iowa Code section 13B.2

CHAPTER 1
ADMINISTRATION

CHAPTER 2
PETITIONS FOR RULE MAKING
(Uniform Rules)

CHAPTER 3
DECLARATORY ORDERS
(Uniform Rules)

CHAPTER 4
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES
(Uniform Rules)

CHAPTER 5
AGENCY PROCEDURE FOR RULE MAKING
(Uniform Rules)

CHAPTER 12
CLAIMS FOR INDIGENT DEFENSE SERVICES

CHAPTER 13
CLAIMS FOR OTHER PROFESSIONAL SERVICES

CHAPTER 14
CLAIMS FOR ATTORNEY FEES IN 600A TERMINATIONS

CHAPTER 7
DEFINITIONS

493—7.1(13B,815) Definitions. As used in these rules, unless the context otherwise requires, the following definitions apply:

"Affidavit of financial status" means a full written disclosure of all income, assets, liabilities, dependents, and other information required to determine if an applicant qualifies for legal assistance by an appointed attorney.

"Appeal" means a proceeding, other than an interlocutory appeal, application for discretionary review, or juvenile court petition on appeal, filed with the Iowa supreme court.

"Applicant" means a person requesting legal assistance by an appointed attorney.

"Appointed attorney" means an attorney appointed by the court to represent an indigent person.

"Assets" means all resources or possessions of the applicant.

"Attorney" means an individual licensed to practice law in Iowa.

"Attorney time" means the total time the attorney appointed to a case spends on in-court time, out-of-court time, and in travel time attributable to that specific case. Attorney time does not include time spent performing clerical activities.

"Case" means all charges or allegations arising from the same transaction or occurrence or contained in the same trial information or indictment in a criminal proceeding or in the same petition in a civil or juvenile proceeding. A probation violation or contempt proceeding is a case separate from the case out of which the violation or contempt arose.

"Child" or *"juvenile"* means a person so defined in Iowa Code chapter 232.

"Claim" means an application or request for payment.

"Claimant" means an appointed attorney or other person seeking reimbursement of costs or fees payable from the indigent defense fund.

"Claims for other professional services" means claims submitted by nonattorneys, including but not limited to investigators, foreign language interpreters, experts, certified shorthand reporters, and persons conducting medical or psychological evaluations.

"Clerical activities" means activities including, but not limited to, opening files; closing files; making photocopies; mailing; opening mail; sending cover letters; transmitting copies of documents to a client, other party or clerk of court; sending a fax; picking up or delivering documents, internal file memos or instructions to staff; scheduling; or billing.

"Contract" means a written agreement between the state public defender and an attorney to provide legal services to an indigent person. The contract may be for the provision of legal services at either the trial court level or the appellate court level.

"County base" means the amount of expenses in juvenile cases for which the county remains liable pursuant to Iowa Code section 232.141(2).

"Court-appointed attorney" means an attorney appointed by the court to represent an indigent person.

"Date of service" means, for adult fee claims, the date of filing of an order indicating that the case was dismissed or the client was acquitted or sentenced, the date of mistrial, the date a warrant was issued for the client, or the date of a court order authorizing the attorney's withdrawal from a case prior to the date of a dismissal, acquittal, sentencing, mistrial or the issuance of a warrant. If a motion for reconsideration is filed, the date on which the court rules on that motion is the date of service. For interim claims or claims for professional services performed by nonattorneys, "date of service" means the last date on the itemization. For juvenile claims, "date of service" means the date of filing of an order as a result of the dispositional hearing or most recent review hearing, the date on which the client ceased to be a party in the CINA case, the date of a court order authorizing the attorney's withdrawal from a case that was not dismissed, the date jurisdiction is waived to adult court, the date on which venue is changed, or the date of dismissal. For noncontract appellate claims, "date of service" means the date on which the procedendo issues or the case is dismissed. For contract appellate claims, "date of service" means the date on which the case was dismissed, the date of a court order authorizing the attorney's withdrawal prior to the filing

of the page-proof brief, the date on which the proof brief was filed, or the date on which the procendendo was issued. For claims filed as a result of a notice of action letter, "date of service" means the date of the notice of action letter. For claims filed as a result of a court order after hearing for review of the fee claim, "date of service" means the date of the order.

"Department" means the department of inspections and appeals.

"Expert witness" or *"expert"* means a person who is retained to render an opinion regarding an issue relevant to a case, whether or not the person actually testifies in court.

"Family" or *"household"* means the applicant, applicant's spouse, including a common-law spouse, and applicant's children living in the same residence.

"Fee limitations" means the attorney fee limitations established by the state public defender for specific classes of cases as specified in rule 493—12.6(13B,815), together with out-of-pocket expenses approved by the state public defender, whether submitted by a public defender, by an appointed attorney pursuant to 493—Chapter 12, or by another professional pursuant to 493—Chapter 13.

"Fees" means the consideration paid to an appointed attorney to represent an indigent person.

"Fiscal year" means the 12-month period beginning July 1 and ending June 30.

"Governmental assistance program" means any public assistance program from which a person is receiving assistance.

"Income" means any money received from any source, including but not limited to remuneration for labor, products or services; money received from governmental assistance programs; tax refunds; prize winnings; pensions; investments; and money received from any other source.

"In-court time" means time spent by an appointed attorney engaged before a judge or jury including, but not limited to, arraignments, bail hearings, pretrial conferences, pretrial motion hearings, evidentiary hearings, jury selection, trial, plea proceedings, posttrial hearings, and probation violation hearings. In-court time does not include time spent at foster care review board hearings, staffings, family drug court, or any other meetings with other state agencies.

"Indigent" means a person entitled to an appointed attorney pursuant to Iowa Code section 815.9.

"Juvenile proceeding" means a case in juvenile court wherein the attorney acts as guardian ad litem for the child in interest or provides legal counsel for the child, parent, guardian or custodian.

"Liabilities" means all living, business or farming expenses and fixed debts.

"Local public defender" means an attorney in the trial division of the state public defender system who performs the duties outlined in Iowa Code section 13B.9.

"Notice of action letter" means a letter sent by the state public defender to notify the claimant that the claimant's fees or expenses were reduced.

"Out-of-court time" means time actually spent by the attorney appointed to the case in drafting documents, case preparation, depositions and other discovery, client or witness interviews, investigation, research, brief drafting, conferences or negotiations with opposing counsel or the court, reviewing records, and other productive case-related time that is not in-court time or travel time. Out-of-court time does not include clerical activities.

"Paralegal time," which is payable from the indigent defense fund, means time spent in a Class A felony case at the trial court level in which only one attorney is appointed preparing pleadings and motions, reviewing transcripts, performing legal research, and interviewing witnesses and may include time spent in court assisting the appointed attorney. Paralegal time does not include typing, scheduling, answering the telephone, talking on the telephone except when interviewing witnesses, or other clerical activities or activities that duplicate work performed by the appointed attorney. Paralegal time is not payable in any other cases or in Class A felony cases in which two attorneys are appointed.

"Person" means an individual, corporation, limited liability company, government or governmental subdivision or association, or any legal entity.

"Poverty income guidelines" means the annual poverty income guidelines established by the U.S. Department of Health and Human Services (DHHS).

"Rules of criminal procedure" means the rules prescribed by the supreme court that govern criminal actions and proceedings in all courts in the state.

"State public defender" means the state public defender appointed pursuant to Iowa Code chapter 13B and those other persons authorized to act on behalf of the state public defender.

"State public defender system" means a system for providing defense services within the state by means of a centrally administered organization having a full-time staff.

"Timely claim" means a claim submitted to the state public defender for payment within 45 days of the date of service in a case in which the attorney was appointed after June 30, 2004. A claim not submitted within 45 days of the date of service shall be deemed a timely claim if the delay in submitting the claim was due to the death of the claimant or due to the extended illness or hospitalization of the claimant within 5 days before the expiration of the 45-day limitation. A timely claim returned to the claimant for additional information shall continue to be deemed timely only if resubmitted with the required information within 45 days of being returned by the state public defender.

"Travel time," which is payable from the indigent defense fund, means reasonable and necessary time spent by the attorney for travel under one of the following circumstances:

1. To and from the scene of a crime;
2. To and from the location of a pretrial hearing, trial, or posttrial hearing, if the venue has been changed from the county in which the crime occurred or if the location of the court hearing has been changed to a different county for the convenience of the court;
3. To and from the place of incarceration of a client in a postconviction relief case, criminal appeal, or postconviction relief appeal;
4. To and from the place of detention of a client in a case if the place of detention is other than the county seat of the county in which the action is pending;
5. To and from the location of the placement of a child in a juvenile case if the guardian ad litem is required by statute to visit the placement and the placement is located in Iowa, but outside the county in which the case is pending;
6. To and from the location of the placement of a child in a juvenile case if the guardian ad litem is required by statute and court order to visit the placement and the placement is outside the state of Iowa;
7. To and from a court of appeals or supreme court argument not held in Des Moines;
8. To and from the location where the deposition of an expert witness is being taken; or
9. Other travel for which authorization is obtained from the state public defender.

"Written" as used in these rules may include electronically transmitted communication to the extent permitted by rules of the state public defender.

This rule is intended to implement Iowa Code chapters 13B and 815.

[**ARC 9293B**, IAB 12/29/10, effective 12/7/10]

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CHAPTER 11
ATTORNEY FEE CONTRACTS

493—11.1(13B) Scope. This chapter sets forth the rules for private attorneys entering into contracts for indigent defense legal services with the state public defender. See 493—Chapter 7 for definitions of terms used in this chapter.

493—11.2(13B) Contracts. An attorney may enter into a contract with the state public defender for the provision of legal services to indigent persons at either the trial level or the appellate level. Nothing in this rule is intended to imply that an attorney may not have both a contract for trial court work and a contract for appellate work.

11.2(1) To be eligible to contract with the state public defender, an attorney must be licensed to practice law in the state of Iowa.

11.2(2) A copy of an original contract is available from the Office of the State Public Defender, Lucas State Office Building, Des Moines, Iowa 50319-0087, by telephoning (515)242-6158, or on the Web at http://spd.iowa.gov.

[**ARC 9293B**, IAB 12/29/10, effective 12/7/10]

493—11.3(13B) Notice of proposed contract. The state public defender will give notice to attorneys of the availability of contracts for indigent defense legal services in a manner reasonably calculated to make attorneys aware of the availability of the contracts.

493—11.4(13B) Contract approval or denial.

11.4(1) The state public defender or a person designated by the state public defender may confer with judges, attorneys and others with knowledge of a potential contracting attorney's competence, effectiveness, trustworthiness, and ability to provide services to eligible individuals, and may conduct such additional investigation as deemed warranted in the sole discretion of the state public defender. The information received may be taken into consideration in determining whether it would be in the best interests of the state to enter into an initial or renewal contract with the potential contracting attorney.

11.4(2) The state public defender or a person designated by the state public defender may hold discussions with, or otherwise obtain information from, a potential contracting attorney to determine the attorney's qualifications and ability to perform the conditions of an initial or renewal contract.

11.4(3) The state public defender or a person designated by the state public defender may hold discussions with, or otherwise obtain information from, a potential contracting attorney to establish under an initial or renewal contract the types of cases the contracting attorney will handle and the geographic area in which the cases will be handled.

11.4(4) The state public defender may decline to award an initial or renewal contract to a proposed contracting attorney if the state public defender determines that the contract would not be in the best interests of the state, as described in rule 493—11.8(13B). The state public defender may limit the contract to specific types of cases, a specified geographic area, or both. The state public defender shall give written notice of this action to the attorney. The attorney may seek reconsideration of this decision in the manner prescribed in rule 493—11.9(13B).

11.4(5) Nothing contained in this rule shall obligate the state public defender to enter into an initial or renewal contract if the state public defender determines that it is not in the best interests of the state to enter into such contract.

493—11.5(13B) Contract elements.

11.5(1) Contract elements. The state public defender may enter into a contract with a private attorney for the provision of legal services to indigents in cases at the trial court level. The state public defender may also enter into a contract with a private attorney for the provision of legal services to indigents in cases at the appellate level.

11.5(2) A contract can only be in force and effect when a contract acceptance form is signed by the contracting attorney and approved by the state public defender.

11.5(3) The contracting attorney shall be an independent contractor and shall not be an agent or employee of the state of Iowa. The attorney shall exercise the attorney's best independent professional judgment on behalf of clients to whom the attorney is assigned.

11.5(4) After a contract has been awarded, the state public defender shall notify the clerks of court of the counties in which the contracting attorney has requested placement on the list of attorneys willing to provide services in those counties.

11.5(5) A contract with a private attorney should cover, but not be limited to, the following subjects:

a. The categories of cases in which the attorney is to provide services;

b. The term of the contract and the responsibility of the attorney for provision of services in cases undertaken pursuant to the contract;

c. Identification of the attorney(s) who will perform legal representation under the contract;

d. A prohibition against assignment of the obligations undertaken pursuant to the contract, including a prohibition against substitution of counsel without prior consent of the state public defender or the court;

e. The qualifications of the contracting attorney to undertake legal representation pursuant to the contract;

f. A description of the compensation to be paid and the manner of payment;

g. A description of any expenses, such as support services, investigative services and expert witness expenses, which may be provided under the contract;

h. A description of the record-keeping and reporting requirements under the contract;

i. A description of the manner in which the contract may be terminated;

j. A description of the manner of disposition of ongoing obligations following termination.

11.5(6) Compensation. Unless the contract provides for a different rate or manner of payment, the attorney shall be compensated as set forth in rule 493—12.4(13B,815) for work performed pursuant to a contract for services at the trial court level and rule 493—12.5(13B,815) for work performed pursuant to a contract for services at the appellate level.

11.5(7) Contract form. Unless the attorney and state public defender agree in writing to vary the terms of the contract between them, the terms contained in the Legal Services Contract Indigent Defense Casework No. 493-10 shall constitute the agreement between the parties for the provision of legal services at the trial court level. The terms of Legal Services Contract Appellate Casework No. 493-10A shall constitute the agreement between the parties for the provision of legal services at the appellate level.

11.5(8) No guarantee of appointments. An attorney under contract with the state public defender is not guaranteed any minimum number of court appointments. The process by which attorneys under contract with the state public defender are appointed to specific cases is governed by Iowa Code chapters 814 and 815. In making appointment decisions, the court may take into consideration any factor it deems appropriate including, but not limited to, the experience of the attorney and the difficulty of the case pursuant to Iowa Code section 815.10(4). The state public defender shall retain sole authority to determine the length of each contract or contract renewal.

[**ARC 8090B**, IAB 9/9/09, effective 9/15/09; **ARC 8372B**, IAB 12/16/09, effective 1/20/10; **ARC 9293B**, IAB 12/29/10, effective 12/7/10]

493—11.6(13B) Contract renewal. Prior to renewal of any contract, the state public defender may contact judges, attorneys, court personnel, and others to determine if any existing contract is being properly fulfilled and may conduct such additional investigation as is described in rule 493—11.4(13B). If the state public defender has determined that a contract renewal is in the best interests of the state, the state public defender may offer a new contract to the contracting attorney. The contracting attorney may accept the new contract by signing the contract and returning it to the state public defender within 30 days of the date on which the contract is submitted to the contracting attorney. If a contracting attorney is not offered a contract renewal, the state public defender shall give the contracting attorney written notice of this action. The attorney may seek reconsideration of this decision in the manner prescribed in rule 493—11.9(13B).

493—11.7(13B) Termination.

11.7(1) *Termination at will.* Either the state public defender or the contracting attorney may terminate a contract upon 30 days' advance written notice to the other party for any reason or no reason. Such termination may affect the entire contract, or may relate solely to a particular county or geographical area, or particular type of case.

11.7(2) *Termination for cause.*

a. A contract for indigent defense shall automatically terminate without notice upon the suspension or revocation of the attorney's license to practice law in the state of Iowa.

b. The state public defender may issue a notice of default based on any of the grounds described in rule 493—11.8(13B). A notice of default shall state the grounds of default and, if feasible, request that the contracting attorney remedy the default within 10 days of the date of the notice. If the events triggering the notice of default continue to be evidenced more than 10 days beyond the date of written notice, the state public defender may immediately terminate the contract without further notice by issuing a notice of termination. An attorney may seek reconsideration of the state public defender's decision to terminate a contract based on the attorney's default in the manner described in rule 493—11.9(13B).

493—11.8(13B) Grounds to deny or terminate a contract. In determining whether the award, renewal, or termination of a contract is in the best interests of the state, the state public defender may take into consideration factors such as, but not limited to, the following:

1. The attorney's compliance with the terms of an existing or prior contract to represent indigent persons;
2. Any form of dishonesty or deception directed to judicial officials, the state public defender, indigent persons, other clients, or any other person in the practice of law;
3. Unprofessional or unethical conduct, or other act or omission that is or may be detrimental or harmful to indigent representation;
4. An attorney's failure to attend, or untimely attendance at, hearings, depositions, or other case-related proceedings;
5. An attorney's failure to abide by a court order, applicable statutes or administrative rules governing indigent representation, or local or state rules of procedure applicable to the cases in which the attorney has been appointed;
6. Repetitive, willful, deceptive, unexplained or uncorrected errors in claims for fees;
7. Disciplinary action against a legal or other professional license or conviction of a crime in any jurisdiction when the disciplinary action or conviction implicates an attorney's honesty, trustworthiness, or competence to practice law, or is otherwise related to the practice of indigent defense;
8. Use of alcohol or controlled substances during court proceedings or in a manner impairing competent performance;
9. Judicial orders or rulings finding that an attorney engaged in untruthful, incompetent, unprofessional, or unethical behavior in the practice of indigent defense, submission of fee claims, or otherwise in the practice of law; or
10. Any other behavior implicating an attorney's competence, effectiveness, or trustworthiness in the practice of indigent defense.

493—11.9(13B,17A) Reconsideration.

11.9(1) *Written notice.* A request for reconsideration is perfected by giving written notice of the request for reconsideration to the state public defender within ten business days of the date of mailing of the notice of denial of an initial or renewal contract, or notice of termination following issuance of a notice of default. A request for reconsideration must be in writing and must specify the factual or legal errors the attorney contends were made by the state public defender. The attorney may provide such additional information, explanation or documentation as the attorney believes would be relevant to the reconsideration decision. The request for reconsideration is deemed made on the date of the United States Postal Service nonmetered postmark or the date of personal service on the state public defender.

11.9(2) *Exhaustion of administrative remedies.* A request for reconsideration of the state public defender's decision to deny or terminate a contract for cause is an administrative prerequisite to seeking any form of judicial review pursuant to Iowa Code chapter 17A.

11.9(3) *Informal conference.* Upon receipt of a request for reconsideration, the state public defender or a person designated by the state public defender may schedule an informal conference with the attorney if in the state public defender's judgment such a conference may foster resolution of the dispute. To the extent that the participation of the state public defender or a person designated by the state public defender in an informal conference could be considered personal investigation as that term is used in Iowa Code section 17A.17, an attorney agreeing to participate in an informal conference waives the right to seek to disqualify the state public defender or a person designated by the state public defender from acting as presiding officer or advising the presiding officer in a subsequent contested case proceeding based solely on the ground of personal investigation during an informal conference. The attorney does not waive the right to raise any other type of disqualification.

11.9(4) *Reconsideration decision.* The state public defender shall issue a written reconsideration decision which may uphold, reverse, or modify the initial decision to deny or terminate a contract. The reconsideration decision is final agency action, unless an attorney timely requests a contested case hearing pursuant to rule 493—11.10(13B,17A).

493—11.10(13B,17A) Contested case hearing.

11.10(1) Written request for contested case hearing. An attorney who is aggrieved by a reconsideration decision and who desires to contest the factual basis for the reconsideration decision shall request a contested case hearing within 10 days of the date the reconsideration decision is mailed. The request for contested case hearing shall identify the fact issues in dispute and any other claimed error, and shall state the manner in which the state public defender is alleged to have relied upon erroneous facts.

11.10(2) Procedures. The request for contested case hearing is deemed made on the date of the United States Postal Service nonmetered postmark or the date of personal service on the state public defender. A contested case hearing shall be conducted pursuant to the procedures set forth in 481 IAC Chapter 10.

11.10(3) A timely request for contested case hearing is an administrative prerequisite to seeking any form of judicial review pursuant to Iowa Code chapter 17A.

11.10(4) Presiding officer. The state public defender or a person designated by the state public defender may preside over the contested case hearing and issue a final decision, or the state public defender may request that the hearing be conducted by an administrative law judge from the department of inspections and appeals who shall issue a proposed decision subject to review by or appeal to the state public defender. If the notice of hearing does not identify an administrative law judge as the presiding officer, an attorney may file a written request that an administrative law judge serve as the presiding officer at hearing. Such request must be filed within 20 days after service of the notice of hearing by certified mail, return receipt requested, to the attorney's last-known address. The state public defender may deny the request only upon a finding that one or more of the following apply:

a. There is a compelling need to expedite issuance of a final decision.

b. The case involves significant policy issues of first impression that are inextricably intertwined with the factual issues presented.

c. Funds are unavailable to pay the costs of an administrative law judge and possible resulting interagency appeal.

d. The request was not timely made.

e. The demeanor of the witnesses is likely to be dispositive in resolving the disputed factual issues.

493—11.11(13B,17A) Judicial review.

11.11(1) The final decision by the state public defender to deny an attorney's request to enter into an initial or renewal contract for indigent representation or to terminate such a contract for cause following issuance of a notice of default is reviewable pursuant to Iowa Code chapter 17A.

11.11(2) Nothing in this rule shall prevent the informal resolution of a decision to deny or terminate an initial or renewal contract through mutually agreeable settlement at any stage of the proceeding.

These rules are intended to implement Iowa Code chapter 13B.

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[1] 12/29/04 effective date delayed 70 days by the Administrative Rules Review Committee at its meeting held 12/14/04.

CHAPTER 12
CLAIMS FOR INDIGENT DEFENSE SERVICES

493—12.1(13B,815) Scope. This chapter sets forth the rules for submission, payment and court review of indigent defense fee claims. See 493—Chapter 7 for definitions of terms used in this chapter.

12.1(1) The state public defender will pay from the indigent defense fund attorney fees and costs for the following types of cases: commitment of sexually violent predators under Iowa Code chapter 229A; contempts; postconviction relief proceedings to the extent authorized under Iowa Code chapter 822; juvenile justice under Iowa Code section 232.141(3)(c); guardians ad litem for children in juvenile court under Iowa Code chapter 600 or respondents under Iowa Code chapter 600A; fees for appellate attorneys under Iowa Code section 814.11; fees to attorneys under Iowa Code section 815.7; fees for court-appointed counsel under Iowa Code section 815.10; violation of probation or parole under Iowa Code chapter 908; indigent's right to transcript on appeal under Iowa Code section 814.9; indigent's application for transcript in other cases under Iowa Code section 814.10; and special witnesses for indigents under Iowa Code section 815.4.

12.1(2) The state public defender will not pay for the costs for any type of administrative proceeding or any other proceeding under Iowa Code chapter 598, 600, 600A, 633, or 915 or other provisions of the Iowa Code.

12.1(3) The Iowa Code requires the state public defender to approve only those indigent defense fee claims that are reasonable and appropriate under applicable statutes. In exercising this duty, the state public defender publishes rules and makes judgments considering what is statutorily permitted, fair for claimants, fair for indigent clients (who, by law, are required to reimburse the state for the costs of their defense), and consistent with good stewardship of public appropriations.

493—12.2(13B,815) Submission and payment of attorney claims.

12.2(1) Court-appointed attorneys shall submit written claims to the state public defender for review, approval and payment. These claims shall include the following:

a. A completed fee claim on a form promulgated by the state public defender. Adult fee claims, including misdemeanor appeals to district court, postconviction relief and applications for discretionary review or applications for interlocutory appeals to the Iowa supreme court, must be submitted on an Adult form. Juvenile fee claims, including petitions on appeal and applications for interlocutory appeals, must be submitted on a Juvenile form. Appellate fee claims, including claims for work performed after the granting of an application for discretionary review or for interlocutory appeal, or if full briefing is ordered following a petition on appeal, must be submitted on an Appellate form. The claim forms may be obtained from the clerk of district court or downloaded from the state public defender Web site: www.spd.state.ia.us. Claims submitted using forms downloaded from the Web site that do not comply with the instructions on the Web site may be returned to the claimant for additional information and resubmission.

b. A copy of all orders appointing the attorney to the case.

(1) The appointment order must be signed by the court and either dated by the court or have a legible file-stamp.

(2) Claims for probation or parole violations and contempt actions are considered new cases, and the attorney must submit a copy of an appointment order for these claims. Appointment orders in parole violation cases to which the attorney was appointed on or after May 5, 2005, must also contain the following findings:

1. The alleged parole violator requests appointment of counsel;
2. The alleged parole violator is indigent as defined in Iowa Code section 815.9;
3. The alleged parole violator, because of lack of skill or education, would have difficulty in presenting the alleged violator's version of a disputed set of facts, particularly when presentation requires the examining or cross-examining of witnesses or the offering or dissecting of complex documentary evidence; and

4. The alleged parole violator has a colorable claim that the alleged violation has not been committed, or there are substantial reasons which justify or mitigate the violation and make revocation inappropriate.

(3) If the venue is changed in a juvenile case, an order appointing the attorney in the new county must be submitted.

(4) An appointment order is not necessary for trial counsel to request or resist an interlocutory appeal or an application for discretionary review.

(5) An appointment order is not necessary if the state public defender determines the appointment order is unnecessary.

c. A copy of any application and court order authorizing the attorney to exceed the attorney fee limitations.

d. A copy of any court order that affects the amount to be paid or the client's right to counsel.

e. An itemization detailing all work performed on the case for which the attorney seeks compensation.

(1) The itemization must separately state the date and amount of time spent on each activity. Time may be reported in either tenths or hundreths of an hour on the itemization but must be recorded in tenths of an hour on the claim form. Time listed in hundredths of an hour on the claim form will be reduced to the nearest tenth of an hour.

(2) The itemization shall separately designate time claimed for in-court time, out-of-court time, paralegal time and travel time.

(3) The itemization must be in chronological order.

(4) The itemization must be typed in at least 10-point type on 8½″ × 11″ paper.

(5) If the itemization does not indicate the date of the disposition of the case, a copy of the dispositional order must be attached to the claim.

f. If the attorney was privately retained to represent the client prior to appointment, a copy of any representation agreement, written notice of the dollar amount paid to the attorney, and an itemization of services performed and how any funds provided were spent during the period prior to the court appointment. The state public defender will review the amount paid and hours spent before and after the court appointment in determining the appropriate attorney compensation on the claim.

12.2(2) The state public defender shall forward claims to the department for processing and payment only after all reporting requirements have been complied with and the claim has been approved by the state public defender. Claims returned to the attorney for additional information will be processed after the requested information is received.

12.2(3) Claims submitted prior to the date of service will be returned to the claimant and may be resubmitted for processing after the date of service.

12.2(4) Claims for compensation in excess of applicable rates are not payable under the attorney's appointment and will be reduced.

12.2(5) Claims for services rendered prior to the effective date of the attorney's appointment are not payable under the attorney's appointment, and that portion will be denied.

12.2(6) For cases to which the attorney is appointed after June 30, 2004, claims that are not timely will be denied. Time billed on claims which are denied, or which could have been denied, pursuant to this subrule may be included in subsequent claims if timely submitted with regard to a subsequent date of service in the same case. For purposes of this subrule, a probation, parole, or contempt proceeding shall not be deemed the "same case" as the underlying proceeding.

12.2(7) Claims for services that contain charges that are either not reasonable or not appropriate are not payable under the attorney's appointment and will be denied.

12.2(8) Claims for clerical activities, overhead, preparation of the fee claim or itemization of services; for obtaining, preparing, or reviewing an application or order to exceed the fee limitations; or for preparation of a motion to review or order and any subsequent hearing for review of an attorney fee claim are not payable under the attorney's appointment and will be denied.

12.2(9) Claims for compensation from attorneys whose appointment as counsel or guardian ad litem at the appellate level does not comply with Iowa Code section 814.11 will be denied.

12.2(10) Claims for compensation from attorneys whose appointment as counsel or guardian ad litem at the trial level was entered on or after July 1, 2009, and received by the state public defender on or after September 15, 2009, will be denied if the appointment does not comply with Iowa Code section 815.10.

12.2(11) Time and expenses claimed by an attorney in withdrawing from a case, or related to withdrawing from a case, in order to either retire from the practice of law or pursue another job will be denied.

12.2(12) The following applies to claims by a guardian ad litem for a child who is aged 18 or older and involved in a juvenile court proceeding:

a. The court must enter an order appointing the guardian ad litem for the limited purposes of continuing a relationship with the child and to provide advice to the child relating to the child's transition plan under Iowa Code section 232.2 beyond the child's eighteenth birthday.

b. Neither a parent nor guardian of the child in interest is entitled to court-appointed counsel during the post-age 18 transition period.

c. The guardian ad litem appointment shall end by the earlier of an order of the court relieving the guardian ad litem of further duties or an order of the court closing the juvenile court case.

12.2(13) A court order that affects the amount of a claim and is entered after the date of the state public defender's action, except following court review as provided in rule 493—12.9(13B,815), is void. See Iowa Code section 13B.4(4).

12.2(14) Time and expenses claimed by an attorney for representing a parent in a child in need of assistance case or termination of parental rights case for work performed subsequent to the date on which the termination of that parent's parental rights becomes final, either on appeal or because no appeal was taken, will be denied.

[**ARC 8090B**, IAB 9/9/09, effective 9/15/09; **ARC 8372B**, IAB 12/16/09, effective 1/20/10; **ARC 9293B**, IAB 12/29/10, effective 12/7/10]

493—12.3(13B,815) Interim claims. Claims will be paid at the conclusion of the case unless one of the following applies:

12.3(1) *Juvenile cases.* An initial claim for services in a juvenile case may be submitted after the dispositional hearing, if any. Subsequent claims may be submitted after each court hearing held in the case. A court hearing does not include family drug court, staffings or foster care review board hearings.

12.3(2) *Appellate cases.* A claim for work performed to date by an attorney having an appellate contract with the state public defender may be submitted in appellate cases after filing of the attorney's proof brief. A subsequent claim may be submitted at the conclusion of the case.

12.3(3) *Specific cases.* Interim claims in Class A felony cases may be submitted once every three months, with the first claim submitted at least 90 days following the effective date of the attorney's appointment.

12.3(4) *Change of employment.* If an attorney is changing law firms, the attorney may submit a claim to end billing at one firm and start billing at the new firm. If payments are to be made to someone other than the law firm which the attorney is leaving, both the attorney and the law firm must advise the state public defender in writing that the attorney is leaving the firm and where the payments should be made.

12.3(5) *Other cases.* In all other cases, claims filed prior to the conclusion of the case will not be paid except with consent of the state public defender.

12.3(6) *Approval of interim claims.* Approval of any interim claims shall not affect the right of the state public defender to review subsequent claims or the aggregate amount of the claims submitted.

493—12.4(13B,815) Rate of compensation. Unless the attorney has a contract that provides for a different manner or rate of payment, the following hourly rates shall apply to payment of all claims for cases to which the attorney was appointed after June 30, 1999, and before July 1, 2006:

Attorney time:	Class A felonies	$60/hour
	Class B felonies	$55/hour
	All other criminal cases	$50/hour
	All other cases	$50/hour
Paralegal time:		$25/hour

Unless the attorney has a contract that provides for a different manner or rate of payment, the following hourly rates shall apply to payment of all claims for cases to which the attorney was appointed after June 30, 2006, and before July 1, 2007:

Attorney time:	Class A felonies	$65/hour
	All other criminal cases	$60/hour
	All other cases	$55/hour
Paralegal time:		$25/hour

Unless the attorney has a contract that provides for a different manner or rate of payment, the following hourly rates shall apply to payment of all claims for cases to which the attorney was appointed after June 30, 2007:

Attorney time:	Class A felonies	$70/hour
	Class B felonies	$65/hour
	All other criminal cases	$60/hour
	All other cases	$60/hour
Paralegal time:		$25/hour

12.4(1) *Applicability to juvenile cases.* In a juvenile case to which the attorney was appointed before July 1, 1999, the state public defender will pay the attorney $50 per hour for all services performed following the dispositional hearing or the first regularly scheduled review hearing occurring after June 30, 1999. In a juvenile case to which the attorney was appointed after June 30, 1999, but before July 1, 2006, the state public defender will pay the attorney $55 per hour for all services performed following the dispositional hearing or the first regularly scheduled review hearing occurring after June 30, 2006. In a juvenile case to which the attorney was appointed after June 30, 2006, but before July 1, 2007, the state public defender will pay the attorney $60 per hour for all services performed following the dispositional hearing or the first regularly scheduled review hearing occurring after June 30, 2007. However, the attorney must file separate claims for services before and after said hearing. If a claim is submitted with two hourly rates on it, the claim will be paid at the lower applicable rate.

12.4(2) *Appointments before July 1, 1999.* In a case to which the attorney was appointed before July 1, 1999, attorney time shall be paid at a rate that is $5 per hour less than the rates established pursuant to 2000 Iowa Acts, chapter 1115, section 10. Claims for compensation in excess of these rates are not payable under the attorney's appointment and will be reduced.

12.4(3) *Applicability to appellate contracts.* This rule shall not apply to claims from attorneys with appellate contracts with the state public defender.

12.4(4) *All other cases.* As used in this rule, the term "all other cases" includes appeals, juvenile cases, contempt actions, representation of material witnesses, and probation/parole violation cases, postconviction relief cases, restitution, extradition, and sentence reconsideration proceedings without regard to the level of the underlying charge.

493—12.5(13B,815) Appellate contracts. Subject to the provisions of this rule, an attorney who has entered into an appellate contract with the state public defender shall be paid pursuant to the terms of this rule for each appellate case to which the attorney is appointed. This rule applies to all appellate contract claims received by the state public defender on or after December 7, 2010.

12.5(1) *Frivolous appeals.* In an appeal in which the attorney withdraws from a case either based on a determination that the appeal is frivolous or for any other reason or in which the appeal is dismissed prior to the filing of the attorney's proof brief, the attorney shall be paid for all reasonable, necessary and appropriate hours claimed on the itemization at the rate of $60 per hour.

12.5(2) *Juvenile cases.* For juvenile appeals, the following provisions apply.

a. In a juvenile case in which a petition on appeal is filed, an appointed trial attorney does not need to obtain an appointment order to pursue the petition on appeal. The claim, through the filing of the petition on appeal, must be submitted on a Juvenile form. If an appellate court orders full briefing, subsequent attorney fee claims must be submitted on an Appellate form. Any amount paid on the petition on appeal shall be considered in determining whether the attorney hours claimed on subsequent appellate claims are reasonable and necessary.

b. In an appellate case in which an appointed attorney joins in all or part of the brief of another party, the attorney shall be paid for all reasonable, necessary and appropriate legal services and expenses claimed on the itemization at the rate of $60 per hour.

12.5(3) *Appeals from a guilty plea.* Notwithstanding the provisions of subrule 12.2(1), an attorney who has entered into an appellate contract with the state public defender and whose client is appealing from a judgment as the result of a guilty plea need not provide an itemization of legal services provided in the appeal if the amount of the attorney fee portion of the claim is $600 or less. If the amount of the claim is in excess of $600, the attorney must provide an itemization and will be paid for all reasonable, necessary and appropriate legal services claimed on the itemization at the rate of $60 per hour, together with permissible out-of-pocket expenses.

12.5(4) *Appeals from a trial.* Notwithstanding the provisions of subrule 12.2(1), an attorney who has entered into an appellate contract with the state public defender and whose client is appealing from a judgment as the result of a jury trial or bench trial need not provide an itemization of legal services provided in the appeal if the amount of the attorney fee portion of the claim is $1,800 or less. If the amount of the claim is in excess of $1,800, the attorney must provide an itemization and will be paid for reasonable, necessary and appropriate legal services claimed on the itemization at the rate of $60 per hour, together with permissible out-of-pocket expenses.

12.5(5) *Applications for further review.* In a case in which an application for further review is filed, the attorney will be paid for all reasonable, necessary and appropriate legal services claimed on the itemization at the rate of $60 per hour, together with permissible out-of-pocket expenses.

12.5(6) *Application of fee limitations.* The fee limitations and procedures provided in rule 493—12.6(13B,815) have no application to appellate contracts.

[**ARC 9293B**, IAB 12/29/10, effective 12/7/10]

493—12.6(13B,815) Attorney fee limitations.

12.6(1) *Adult cases.* The state public defender establishes attorney fee limitations for combined attorney time and paralegal time for the following categories of adult cases:

Class A felonies	$18,000
Class B felonies	$3,600
Class C felonies	$1,800
Class D felonies	$1,200
Aggravated misdemeanors	$1,200
Serious misdemeanors	$600
Simple misdemeanors	$300

Simple misdemeanor appeals to district court	$300
Contempt/show cause proceedings	$300
Proceedings under Iowa Code chapter 229A	$10,000
Probation/parole violation	$300
Extradition	$300
Postconviction relief—the greater of $1,000 or one-half of the fee limitation for the conviction from which relief is sought.	

Nothing in this subrule is intended to in any manner diminish, increase, or modify the state public defender's authority to review any and all claims for services as authorized by the Iowa Code.

The fee limitations are applied separately to each case, as that term is defined in rule 493—7.1(13B,815). If more than one charge is included within a case, the charge with the higher fee limitation will apply to the entire case.

For example, in an adult criminal proceeding, if an attorney were appointed to represent a client charged with four counts of forgery arising at four separate times, and if the client were charged in four separate trial informations, the fee limitations for each charge would apply separately. If all four charges were contained in one trial information, the fee limitation would be $1,200 even if there were more than one separate occurrence. If the attorney were appointed to represent a person charged with a drug offense and failure to possess a tax stamp, the fee limitation would be the limitation for the offense with the higher limitation, not the total of the limitations.

If the Iowa Code section listed on the claim form defines multiple levels of crimes and the claimant does not list the specific level of crime on the claim form, the state public defender will use the least serious level of crime in reviewing the claim.

For example, Iowa Code section 321J.2 defines crimes ranging from a serious misdemeanor to a Class D felony. If the attorney does not designate the subsection defining the level of the crime, the state public defender will deem the charge to be a serious misdemeanor.

12.6(2) *Juvenile cases.* The state public defender establishes attorney fee limitations for attorney time for the following categories of juvenile cases:

Delinquency (through disposition)	$1,200
Child in need of assistance (CINA) (through disposition)	$1,200
Termination of parental rights (TPR) (through disposition)	$1,800
Juvenile court review and other postdispositional court hearings	$300
Judicial bypass hearings	$180
Juvenile commitment hearings	$180
Juvenile petition on appeal	$600
Motion for further review after petition on appeal	$300

Nothing in this subrule is intended to in any manner diminish, increase, or modify the state public defender's authority to review any and all claims for services as authorized by the Iowa Code.

The fee limitations are applied separately to each case, as that term is defined in rule 493—7.1(13B,815).

For example, in a juvenile proceeding in which the attorney represents a parent whose four children are the subject of four child in need of assistance petitions, if the court handles all four petitions at the same time or the incident that gave rise to the child in need of assistance action is essentially the same for each child, the fee limitation for the attorney representing the parent is $1,200 for all four proceedings, not $1,200 for each one.

For a child in need of assistance case that becomes a termination of parental rights case, the fee limitations shall apply to each case separately. For example, the attorney could claim up to $1,200 for the child in need of assistance case and up to $1,800 for the termination of parental rights case.

In a delinquency case, if the child has multiple petitions alleging delinquency and the court handles the petitions at the same time, the fee limitation for the proceeding is the fee limitation for one delinquency.

In a juvenile case in which a petition on appeal is filed, the appointed trial attorney does not need to obtain a new appointment order to pursue a petition on appeal. The claim, through the filing of a petition on appeal, must be submitted on a Juvenile form. If an appellate court orders full briefing, the attorney fee claim for services subsequent to an order requiring full briefing must be submitted on an Appellate form and is subject to the rules governing appeals.

12.6(3) *Appellate cases.* Except as provided in this subrule, the state public defender establishes an attorney fee limitation of $2,400 for all reasonable, necessary, and appropriate legal services in appellate cases filed with the Iowa supreme court.

a. In an appeal to which the attorney was appointed after June 30, 1999, and before July 1, 2006, in which the attorney withdraws based on a determination that the appeal is frivolous or in which the appeal is dismissed prior to the filing of the attorney's proof brief, the attorney shall be paid at the rate of $50 per hour, with an attorney fee limitation of $1,000. In an appeal to which the attorney was appointed after June 30, 2006, and before July 1, 2007, in which the attorney withdraws based on a determination that the appeal is frivolous or in which the appeal is dismissed prior to the filing of the attorney's proof brief, the attorney shall be paid at the rate of $55 per hour, with an attorney fee limitation of $1,100. In an appeal to which the attorney was appointed after June 30, 2007, in which the attorney withdraws based on a determination that the appeal is frivolous or in which the appeal is dismissed prior to the filing of the attorney's proof brief, the attorney shall be paid at the rate of $60 per hour, with an attorney fee limitation of $1,200.

b. In an appellate case to which the attorney was appointed after June 30, 1999, and before July 1, 2006, in which an appointed attorney joins in all or part of the brief of another party, the attorney shall be paid at the rate of $50 per hour, with an attorney fee limitation of $500. In an appellate case to which the attorney was appointed after June 30, 2006, and before July 1, 2007, in which an appointed attorney joins in all or part of the brief of another party, the attorney shall be paid at the rate of $55 per hour, with an attorney fee limitation of $550. In an appellate case to which the attorney was appointed after June 30, 2007, in which an appointed attorney joins in all or part of the brief of another party, the attorney shall be paid at the rate of $60 per hour, with an attorney fee limitation of $600.

c. In a juvenile case in which a petition on appeal is filed, an appointed trial attorney does not need to obtain an appointment order to pursue the petition on appeal. The claim, through the filing of the petition on appeal, must be submitted on a Juvenile form. If an appellate court orders full briefing, subsequent attorney fee claims must be submitted on an Appellate form. Any amount paid on the petition on appeal shall be considered in determining whether subsequent appellate claims exceed the fee limitations.

This subrule does not apply to appellate cases to which an attorney with an appellate contract with the state public defender is appointed. See rule 493—12.5(13B,815).

12.6(4) *Claims in excess of fee limitations.* A claim in excess of the attorney fee limitations will not be paid unless the attorney seeks and obtains authorization from the appointing court to exceed the attorney fee limitations prior to exceeding the attorney fee limitations. If authorization is granted, payment in excess of the attorney fee limitations shall be made only for services performed after the date of submission of the request for authorization.

12.6(5) *Retroactivity of authorization.* Authorization to exceed the attorney fee limitations shall be effective only as to services performed after a request for authorization to exceed the attorney fee limitations is filed with the court unless the court enters an order before submission of the claim to the state public defender specifically authorizing a late filing of the application and finding that good cause exists excusing the attorney's failure to file the application prior to the attorney's exceeding the attorney fee limitations. "Good cause" as used in this subrule means a sound, effective and truthful reason.

"Good cause" is more than an excuse, plea, apology, extenuation, or some justification. Inadvertence or oversight does not constitute good cause. Retroactive court orders entered after the date of the state public defender's action on a claim are void. See Iowa Code section 13B.4(4).
[**ARC 9293B**, IAB 12/29/10, effective 12/7/10]

493—12.7(13B,815) Reimbursement for specific expenses.

12.7(1) The state public defender shall reimburse the attorney for the payments made by the attorney for necessary certified shorthand reporters, investigators, foreign language interpreters, evaluations, and experts, if the following conditions are met:

a. The attorney obtained court approval for a certified shorthand reporter, investigator, foreign language interpreter, evaluation or expert prior to incurring any expenses with regard to each.

b. A copy of the application and order granting authority accompanies the claim.

c. The certified shorthand reporter, investigator, foreign language interpreter, provider of an evaluation or expert does not submit a claim for the same services.

d. The attorney is seeking reimbursement for moneys already expended or certifies that the funds for these services will be used to pay for the certified shorthand reporter, investigator, foreign language interpreter, evaluation, or expert.

e. A copy of the court order authorizing the expense is attached to the claim.

f. In claims for services of investigators, foreign language interpreters, or experts, a copy of a court order setting the maximum dollar amount of the claim is attached to the claim.

g. In claims for the cost of an evaluation requested by an appointed attorney, the attorney will be reimbursed for the reasonable cost of an evaluation of the client to establish a defense in the case or to determine if the client is competent to stand trial. In either instance, a copy of the court order authorizing the evaluation for one of these specific purposes and an order approving the amount of the evaluation must accompany the claim form. Claims for the cost of an evaluation to be used for any other purpose, such as sentencing or placement, will not be reimbursed.

12.7(2) Nothing contained in this rule is intended to require the attorney to provide notice to any other party prior to seeking such an order or to require the attorney to disclose confidential information, work product, or trial strategy in order to obtain the order.

12.7(3) In an appeal, the state public defender will pay the cost of obtaining the transcript of the trial records and briefs. In such instance, paragraphs 12.7(1)*"b"* to *"d"* shall apply.

12.7(4) Claims for expenses that do not meet these conditions are not payable under the attorney's appointment and will be denied.

493—12.8(13B,815) Reimbursement of other expenses.

12.8(1) The state public defender shall reimburse the attorney for the following out-of-pocket expenses incurred by the attorney in the case to the extent that the expenses are reasonable and necessary:

a. Mileage for automobile travel at the rate of 35 cents per mile. The number of miles driven must be listed in the itemization of services and on the claim form. Other forms of transportation costs incurred by the attorney will be reimbursed with prior approval from the state public defender.

b. The actual cost of lodging, limited by the state-approved rate, is reimbursed only if the attorney is entitled to be paid for travel time for the travel associated with the lodging and the attorney is required to be away from home overnight.

c. The actual cost of meals, limited by the state-approved rate, is reimbursed only if the attorney is entitled to be paid for travel time for the travel associated with these meals.

d. Necessary photocopying at the attorney's office at the rate of 10 cents per copy. The number of copies made must be listed in the itemization of services or on the claim form.

e. Ordinary and necessary postage, toll calls, collect calls, and parking for the actual cost of these expenses. Toll and collect calls will be reimbursed at 10 cents per minute or the actual cost. A receipt for the actual cost must be attached to the claim form. A statement from a correctional facility or jail detailing a standard rate for such calls shall constitute a receipt for purposes of this paragraph. For

parking in excess of $2, a receipt must be attached to the claim form. Claims for the cost of a parking ticket will be denied.

f. Receiving faxes in the attorney's office at the rate of 10 cents per page. There is no direct cost reimbursement for sending a fax unless there is a toll charge associated with it.

g. The actual cost of photocopying or faxing for which the attorney must pay an outside vendor. A receipt for the actual cost must be attached to the claim form.

h. Other claims for expenses such as process service, medical records, videotapes and film will be reimbursed for the actual cost. A receipt or invoice from an outside vendor must be attached to the claim form.

i. Other specific expenses for which prior approval by the state public defender is obtained.

12.8(2) Claims for expenses other than those listed in this rule or at rates in excess of the rates set forth in this rule are not payable under the attorney's appointment and will be reduced or denied.

493—12.9(13B,815) Court review. An attorney whose claim for compensation is denied, reduced, or otherwise modified by the state public defender, for other than mathematical errors, may seek court review of the action of the state public defender.

12.9(1) *Motions for court review.* Court review of the action of the state public defender is initiated by the filing of a motion with the trial court requesting the review. The following conditions shall apply to all such motions:

a. The motion must be filed with the court within 20 days of the action of the state public defender. This time limit is jurisdictional and will not be extended by the filing of another claim or obtaining a court order affecting the amount of the claim.

b. The motion must set forth each and every ground on which the attorney intends to rely in challenging the action of the state public defender.

c. The motion must have attached to it a complete copy of the claim, together with the notice of action that the attorney seeks to have reviewed.

d. A copy of all documents filed must be provided to the state public defender.

e. It is unnecessary for the state public defender to file any response to the motion.

12.9(2) *Hearings.* The following shall apply to hearings on motions for court review:

a. The motion shall be set for hearing by the court. Notice of the hearing on the attorney's request for review shall be provided to the attorney and the state public defender at least ten days prior to the date and time set by the reviewing court.

b. Unless the state public defender appears or specifically indicates an intention to appear in person at the hearing, the state public defender shall participate by telephone. If the state public defender participates by telephone, the state public defender shall be responsible for initiating and paying for the telephone call. If the attorney intends to participate by telephone, the attorney shall notify the state public defender of this intent and provide a telephone number for the hearing at least two business days prior to the date scheduled for the hearing.

c. The burden shall be on the attorney requesting the review.

d. The court shall consider only the issues raised in the attorney's motion.

e. The court shall issue a written ruling on the issues properly presented in the request for review.

f. If a ruling is entered modifying the state public defender's action on the claim, the attorney must file a new claim with the state public defender within 45 days of the date of the court's order modifying the state public defender's action on the claim. A copy of the court's ruling must be attached to the claim form. The date of service on the claim form is the date of the court's order.

12.9(3) *Failure to seek review.* Failure to seek court review within 20 days of the action of the state public defender will preclude court review of the state public defender's action.

493—12.10(13B,815) Payment errors. If an error resulting in an overpayment or double payment of a claim is discovered, the claimant shall notify the clerk of court of the error and shall reimburse the department for the amount of the overpayment. An overpayment that is returned to the department shall be paid by check made payable to the "Treasurer, State of Iowa" and mailed to the Department of

Inspections and Appeals, Indigent Defense Unit, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319. The attorney is responsible for notifying the clerk of court of any payment error.

These rules are intended to implement Iowa Code chapters 13B and 815.

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◊ Two or more ARCs

1 12/29/04 effective date delayed 70 days by the Administrative Rules Review Committee at its meeting held 12/14/04.

CHAPTER 10
INTEREST, PENALTY, EXCEPTIONS TO PENALTY, AND JEOPARDY ASSESSMENTS

[Prior to 12/17/86, Revenue Department[730]]

Rules 701—10.20(421) to 701—10.111(422A) are excerpted from 701—Chs 12, 30, 44, 46, 52, 58, 63, 81, 86, 88, 89, 104, IAB 1/23/91

701—10.1(421) Definitions. As used in the rules contained herein, the following definitions apply unless the context otherwise requires:

10.1(1) *"Department"* means the department of revenue.

10.1(2) *"Director"* means the director of the department or authorized representative.

10.1(3) *"Taxes"* means all taxes and charges arising under Title X of the Iowa Code, which include but are not limited to individual income, withholding, corporate income, franchise, sales, use, hotel/motel, railroad fuel, equipment car, replacement tax, statewide property tax, motor vehicle fuel, inheritance, estate and generation skipping transfer taxes and the environmental protection charge imposed upon petroleum diminution due and payable to the state of Iowa.

701—10.2(421) Interest. Except where a different rate of interest is provided by Title X of the Iowa Code, the rate of interest on interest-bearing taxes and interest-bearing refunds arising under Title X is fixed for each calendar year by the director. In addition to any penalty computed, there shall be added interest as provided by law from the original due date of the return. Any portion of the tax imposed by statute which has been erroneously refunded and is recoverable by the department shall bear interest as provided in Iowa Code section 421.7, subsection 2, from the date of payment of the refund, considering each fraction of a month as an entire month. Interest which is not judgment interest is not payable on sales and use tax, local option tax, and hotel and motel tax refunds. *Herman M. Brown v. Johnson,* 248 Iowa 1143, 82 N.W.2d 134 (1957); *United Telephone Co. v. Iowa Department of Revenue,* 365 N.W.2d 647 (Iowa 1985). However, interest which is not judgment interest accrues on such refunds on or after January 1, 1995, and is payable on sales and use tax, local option tax and hotel and motel tax refunds on or after January 1, 1995.

10.2(1) *Calendar year 1982.* The rate of interest upon all unpaid taxes which are due as of January 1, 1982, will be 17 percent per annum (1.4% per month). This interest rate will accrue on taxes which were due and unpaid as of, or after, January 1, 1982. In addition, this interest rate will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before, on, or after January 1, 1982. This interest rate of 17 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 1982.

EXAMPLES:

1. The taxpayer, X corporation, owes corporate income taxes assessed to it for the year 1975. The assessment was made by the department in 1977. On January 1, 1982, that assessment had not been paid. The rate of interest on the unpaid tax assessed has accrued at the rate of 9 percent per annum (0.75% per month) through December 31, 1981. Commencing on January 1, 1982, the rate of interest on the unpaid tax will thereafter accrue at the rate of 17 percent per annum for 1982 (1.4% per month). If the tax liability is not paid in 1982, the rate of interest will then accrue in 1983 in accordance with the rate fixed by the director as set forth in Iowa Code section 421.7.

2. The taxpayer, Y, owes retail sales taxes assessed to it for the audit period January 1, 1979, through December 31, 1982. The assessment is made on March 1, 1983. For the tax periods in which the tax became due prior to January 1, 1982, the interest rate on such unpaid sales taxes accrued at 9 percent per annum (0.75% per month). Commencing on January 1, 1982, the entire unpaid portion of the tax assessed which was delinquent at that time will begin to accrue interest at the rate of 17 percent per annum. Those portions of the tax assessed first becoming delinquent in 1982 will bear interest at the rate of 17 percent per annum (1.4% per month). In the event that any portion of the tax assessed remains unpaid on January 1, 1983, the rate of interest will then accrue in 1983 in accordance with the rate fixed by the director as set forth in Iowa Code section 421.7.

3. The taxpayer, Z, files a refund claim for 1978 individual income taxes in March 1982. The refund claim is allowed in May 1982, and is paid. Z is entitled to receive interest at the rate of 9 percent per annum (0.75% per month) upon the refunded tax accruing through December 31, 1981, and is entitled

to interest at the rate of 17 percent per annum (1.4% per month) upon such tax from January 1, 1982, until the refund is paid.

4. A's 1981 individual income tax liability becomes delinquent on May 1, 1982. A owes interest, commencing on May 1, 1982, at the rate of 17 percent per annum (1.4% per month). In the event that A does not pay the liability in 1982, the rate of interest will then accrue in 1983 in accordance with the rate fixed by the director as set forth in Iowa Code section 421.7.

5. Decedent died December 15, 1976. The inheritance tax was due 12 months after death, or December 15, 1977. Prior to the due date, the estate was granted an extension of time, until September 1, 1978, to file the return and pay the tax due. The tax, however, was paid March 15, 1982. Interest accrues on the unpaid tax during the period of the extension of time (December 15, 1977, to September 1, 1978) at the rate of 6 percent per annum. Interest accrues on the delinquent tax from September 1, 1978, through December 31, 1981, at the rate of 8 percent per annum. Interest accrues on the delinquent tax from January 1, 1982, to the date of payment on March 15, 1982, at the rate of 17 percent per annum.

6. B files a refund for sales taxes paid for the periods January 1, 1979, through December 31, 1982, in March 1983. The refund is allowed in May 1983. Since no interest is payable on sales tax refunds, B is not entitled to any interest. *Herman M. Brown Co. v. Johnson,* 248 Iowa 1143 (1957). However, interest accrues and is payable on and after January 1, 1995.

The examples set forth in these rules are not meant to be all-inclusive. In addition, other rules set forth the precise circumstance when interest begins to accrue and whether interest accrues for each month or fraction of a month or annually as provided by law. Interest accrues as provided by law, regardless of whether the department has made a formal assessment of tax.

10.2(2) *Calendar year 1983.* The rate of interest upon all unpaid taxes which are due as of January 1, 1983, will be 14 percent per annum (1.2% per month). This interest rate will accrue on taxes which were due and unpaid as of, or after January 1, 1983. In addition, this interest rate will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before, on, or after January 1, 1983. This interest rate of 14 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 1983.

10.2(3) *Calendar year 1984.* The rate of interest upon all unpaid taxes which are due as of January 1, 1984, will be 9 percent per annum (0.8% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after, January 1, 1984. In addition, this interest rate will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before, on, or after January 1, 1984. This interest rate of 9 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 1984.

10.2(4) *Calendar year 1985.* The rate of interest upon all unpaid taxes which are due as of January 1, 1985, will be 10 percent per annum (0.8% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after, January 1, 1985. In addition, this interest rate will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before, on, or after January 1, 1985. This interest rate of 10 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 1985.

10.2(5) *Calendar year 1986.* The interest upon all unpaid taxes which are due as of January 1, 1986, will be 9 percent per annum (0.8% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after, January 1, 1986. In addition, this interest rate will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before, on, or after January 1, 1986. This interest rate of 9 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 1986.

10.2(6) *Calendar year 1987.* The interest upon all unpaid taxes which are due as of January 1, 1987, will be 9 percent per annum (0.8% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after January 1, 1987. In addition, this interest rate will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before, on, or after January 1, 1987. This interest rate of 9 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 1987.

10.2(7) *Calendar year 1988.* The interest upon all unpaid taxes which are due as of January 1, 1988, will be 8 percent per annum (0.7% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after January 1, 1988. In addition, this interest rate will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before, on, or after January 1, 1988. This interest rate of 8 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 1988.

10.2(8) *Calendar year 1989.* The interest upon all unpaid taxes which are due as of January 1, 1989, will be 9 percent per annum (0.8% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after January 1, 1989. In addition, this interest rate will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before, on, or after January 1, 1989. This interest rate of 9 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 1989.

10.2(9) *Calendar year 1990.* The interest upon all unpaid taxes which are due as of January 1, 1990, will be 11 percent per annum (0.9% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after January 1, 1990. In addition, this interest rate will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before, on, or after January 1, 1990. This interest rate of 11 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 1990.

10.2(10) *Calendar year 1991.* The interest upon all unpaid taxes which are due as of January 1, 1991, will be 12 percent per annum (1.0% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after, January 1, 1991. In addition, this interest rate will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before, on, or after January 1, 1991. This interest rate of 12 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 1991.

10.2(11) *Calendar year 1992.* The interest upon all unpaid taxes which are due as of January 1, 1992, will be 11 percent per annum (0.9% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after, January 1, 1992. In addition, this interest rate will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before, on, or after January 1, 1992. This interest rate of 11 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 1992.

10.2(12) *Calendar year 1993.* The interest upon all unpaid taxes which are due as of January 1, 1993, will be 9 percent per annum (0.8% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after, January 1, 1993. In addition, this interest rate will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before, on, or after January 1, 1993. This interest rate of 9 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 1993.

10.2(13) *Calendar year 1994.* The interest upon all unpaid taxes which are due as of January 1, 1994, will be 8 percent per annum (0.7% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after, January 1, 1994. In addition, this interest rate will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before, on, or after January 1, 1994. This interest rate of 8 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 1994.

10.2(14) *Calendar year 1995.* The interest upon all unpaid taxes which are due as of January 1, 1995, will be 9 percent per annum (0.8% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after, January 1, 1995. In addition, this interest rate will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before, on, or after January 1, 1995. This interest rate of 9 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 1995.

10.2(15) *Calendar year 1996.* The interest upon all unpaid taxes which are due as of January 1, 1996, will be 11 percent per annum (0.9% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after, January 1, 1996. In addition, this interest rate will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before, on, or after

January 1, 1996. This interest rate of 11 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 1996.

10.2(16) *Calendar year 1997.* The interest rate upon all unpaid taxes which are due as of January 1, 1997, will be 10 percent per annum (0.8% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after, January 1, 1997. In addition, this interest rate will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before or after January 1, 1997. This interest rate of 10 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 1997.

10.2(17) *Calendar year 1998.* The interest rate upon all unpaid taxes which are due as of January 1, 1998, will be 10 percent per annum (0.8% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after, January 1, 1998. In addition, this interest rate will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before or after January 1, 1998. This interest rate of 10 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 1998.

10.2(18) *Calendar year 1999.* The interest rate upon all unpaid taxes which are due as of January 1, 1999, will be 10 percent per annum (0.8% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after, January 1, 1999. In addition, this interest rate will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before or after January 1, 1999. This interest rate of 10 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 1999.

10.2(19) *Calendar year 2000.* The interest rate upon all unpaid taxes which are due as of January 1, 2000, will be 10 percent per annum (0.8% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after, January 1, 2000. In addition, this interest rate will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before or after January 1, 2000. This interest rate of 10 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 2000.

10.2(20) *Calendar year 2001.* The interest rate upon all unpaid taxes which are due as of January 1, 2001, will be 11 percent per annum (0.9% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after, January 1, 2001. In addition, this interest rate will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before or after January 1, 2001. This interest rate of 11 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 2001.

10.2(21) *Calendar year 2002.* The interest rate upon all unpaid taxes which are due as of January 1, 2002, will be 10 percent per annum (0.8% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after, January 1, 2002. In addition, this interest rate will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before or after January 1, 2002. This interest rate of 10 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 2002.

10.2(22) *Calendar year 2003.* The interest rate upon all unpaid taxes which are due as of January 1, 2003, will be 7 percent per annum (0.6% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after, January 1, 2003. In addition, this interest will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before or after January 1, 2003. This interest rate of 7 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 2003.

10.2(23) *Calendar year 2004.* The interest rate upon all unpaid taxes which are due as of January 1, 2004, will be 6 percent per annum (0.5% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after, January 1, 2004. In addition, this interest will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before or after January 1, 2004. This interest rate of 6 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 2004.

10.2(24) *Calendar year 2005.* The interest rate upon all unpaid taxes which are due as of January 1, 2005, will be 6 percent per annum (0.5% per month). This interest rate will accrue on taxes which are

due and unpaid as of, or after, January 1, 2005. In addition, this interest will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before or after January 1, 2005. This interest rate of 6 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 2005.

10.2(25) *Calendar year 2006.* The interest rate upon all unpaid taxes which are due as of January 1, 2006, will be 8 percent per annum (0.7% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after, January 1, 2006. In addition, this interest will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before or after January 1, 2006. This interest rate of 8 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 2006.

10.2(26) *Calendar year 2007.* The interest rate upon all unpaid taxes which are due as of January 1, 2007, will be 10 percent per annum (0.8% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after, January 1, 2007. In addition, this interest will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before or after January 1, 2007. This interest rate of 10 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 2007.

10.2(27) *Calendar year 2008.* The interest rate upon all unpaid taxes which are due as of January 1, 2008, will be 10 percent per annum (0.8% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after, January 1, 2008. In addition, this interest will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before or after January 1, 2008. This interest rate of 10 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 2008.

10.2(28) *Calendar year 2009.* The interest rate upon all unpaid taxes which are due as of January 1, 2009, will be 8 percent per annum (0.7% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after, January 1, 2009. In addition, this interest will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before or after January 1, 2009. This interest rate of 8 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 2009.

10.2(29) *Calendar year 2010.* The interest rate upon all unpaid taxes which are due as of January 1, 2010, will be 5 percent per annum (0.4% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after, January 1, 2010. In addition, this interest will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before or after January 1, 2010. This interest rate of 5 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 2010.

10.2(30) *Calendar year 2011.* The interest rate upon all unpaid taxes which are due as of January 1, 2011, will be 5 percent per annum (0.4% per month). This interest rate will accrue on taxes which are due and unpaid as of, or after, January 1, 2011. In addition, this interest will accrue on tax refunds which by law accrue interest, regardless of whether the tax to be refunded is due before or after January 1, 2011. This interest rate of 5 percent per annum, whether for unpaid taxes or tax refunds, will commence to accrue in 2011.

This rule is intended to implement Iowa Code section 421.7.

[**ARC 8551B**, IAB 2/24/10, effective 3/31/10; **ARC 9308B**, IAB 12/29/10, effective 2/2/11]

701—10.3(422,423,450,452A) Interest on refunds and unpaid tax.

10.3(1) *Interest on refunds.* For those taxes on which interest accrues on refunds under Iowa Code sections 422.25(3), 422.28, 450.94, and 452A.65, interest shall accrue through the month in which the refund is mailed to the taxpayer and no further interest will accrue unless the department did not use the most current address as shown on the latest return or refund claim filed with the department.

10.3(2) *Interest on unpaid tax.* Interest due on unpaid tax is not a penalty, but rather it is compensation to the government for the period the government was deprived of the use of money. Therefore, interest due cannot be waived. *Vick v. Phinney*, 414 F.2d 444, 448 (5th CA 1969); *Time, Inc. v. United States*, 226 F.Supp. 680, 686 (S.D. N.Y. 1964); *In Re Jeffco Power Systems*, Dep't of

Revenue Hearing Officer decision, Docket No. 77-9-6A-A (1978); *Waterloo Courier, Inc. v. Iowa Department of Revenue and Finance*, Case No. LACV081252, Black Hawk County District Court, December 30, 1999.

This rule is intended to implement Iowa Code sections 422.25(3), 422.28, 423.47, 450.94 and 452A.65.

[**ARC 7761B**, IAB 5/6/09, effective 6/10/09]

701—10.4(421) Frivolous return penalty. A $500 civil penalty is imposed on the return of a taxpayer that is considered to be a "frivolous return." A "frivolous return" is: (1) A return which lacks sufficient information from which the substantial correctness of the amount of tax liability can be determined or contains information that on its face indicates that the amount of tax shown is substantially incorrect, or (2) a return which reflects a position of law which is frivolous or is intended to delay or impede the administration of the tax laws of this state.

If the frivolous return penalty is applicable, the penalty will be imposed in addition to any other penalty which has been assessed. If the frivolous return penalty is relevant, the penalty may be imposed even under circumstances when it is determined that there is no tax liability on the return.

The frivolous return penalty is virtually identical to the penalty for frivolous income tax returns which is authorized in Section 6702 of the Internal Revenue Code. The department will follow federal guidelines and court cases when determining whether or not the frivolous return penalty should be imposed.

The frivolous return penalty may be imposed on all returns filed with the department and not just individual income tax returns. The penalty may be imposed on an amended return as well as an original return. The penalty may be imposed on each return filed with the department.

10.4(1) *Nonexclusive examples of circumstances under which the frivolous return penalty may be imposed.* The following are examples of returns filed in circumstances under which the frivolous return penalty may be imposed:

a. A return claiming a deduction against income or a credit against tax liability which is clearly not allowed such as a "war," "religious," "conscientious objector" deduction or tax credit.

b. A blank or partially completed return that was prepared on the theory that filing a complete return and providing required financial data would violate the Fifth Amendment privilege against self-incrimination or other rights guaranteed by the Constitution.

c. An unsigned return where the taxpayer refused to sign because the signature requirement was "incomprehensible or unconstitutional" or the taxpayer was not liable for state tax since the taxpayer had not signed the return.

d. A return which contained personal and financial information on the proper lines but where the words "true, correct and complete" were crossed out above the taxpayer's signature and where the taxpayer claimed the taxpayer's income was not legal tender and was exempt from tax.

e. A return where the taxpayer claimed that income was not "constructively received" and the taxpayer was the nominee-agent for a trust.

f. A return with clearly inconsistent information such as when 99 exemptions were claimed but only several dependents were shown.

g. A document filed for refund of taxes erroneously collected with the contention that the document was not a return and that no wage income was earned. This was inconsistent with attached W-2 Forms reporting wages.

10.4(2) *Nonexclusive examples where the frivolous return penalty is not applicable.* The following examples illustrate situations where the frivolous return penalty would not be applicable:

a. A return which includes a deduction, credit, or other item which may constitute a valid item of dispute between the taxpayer and the department.

b. A return which includes innocent or inadvertent mathematical or clerical errors, such as an error in addition, subtraction, multiplication, or division or the incorrect use of a table provided by the department.

c. A return which includes a statement of protest or objection, provided the return contains all required information.

d. A return which shows the correct amount of tax due, but the tax due is not paid.

This rule is intended to implement Iowa Code section 421.8.

701—10.5(421) Improper receipt of credit or refund. A person who makes an erroneous application for refund or credit shall be liable for any overpayment received plus interest at the rate in effect under Iowa Code section 421.7, subsection 2. In addition, a person who willfully makes a false or frivolous application for refund or credit with the intent to evade tax or with the intent to receive a refund or credit to which the person is not entitled is guilty of a fraudulent practice and is liable for a penalty equal to 75 percent of the refund or credit claimed.

This rule is intended to implement Iowa Code section 421.27 as amended by 2010 Iowa Acts, House File 2531, section 124.

[**ARC 9103B**, IAB 9/22/10, effective 10/27/10]

PENALTY FOR TAX PERIOD BEGINNING AFTER JANUARY 1, 1991

701—10.6(421) Penalties. A penalty shall be assessed upon all tax and deposits due under the following circumstances:

1. For failure to timely file a return or deposit form there is a 10 percent penalty. This penalty, once imposed, will be assessed on all subsequent amounts due or required to be shown due on the return or deposit form.

EXAMPLE: The taxpayer fails to timely file a return and fails to timely pay the tax due. The department will assess a 10 percent penalty for failure to timely file the return but will not assess a 5 percent penalty for failure to timely pay. The department subsequently audits the untimely filed return and determines additional tax is due. The department shall assess a 10 percent penalty on the additional tax found due by an audit.

2. For failure to timely pay the tax due on a return or deposit form, there is a 5 percent penalty.

3. For a deficiency of tax due on a return or deposit form found during an audit, there is a 5 percent penalty. For purposes of this penalty, the audit deficiency shall be assessed only when there is a timely filed return or deposit form.

Audit deficiency occurs when the department determines additional tax is due.

4. For willful failure to file a return or deposit form with the intent to evade tax, or in the case of willfully filing a false return or deposit form with the intent to evade tax, there is a 75 percent penalty.

The penalty rates are uniform for all taxes and deposits due under this chapter.

The penalty for failure to timely file will take precedence over the penalty for failure to timely pay or an audit deficiency when more than one penalty is applicable.

5. Examples to illustrate the computation of penalty for tax periods beginning on or after January 1, 1991.

The following are examples to illustrate the computation of penalties imposed under rule 10.7(421). For purposes of these examples, interest has been computed at the rate of 12 percent per year or 1 percent per month. The tax due amounts are assumed to be the total amounts required to be shown due when considering whether the failure to pay penalty should be assessed on the basis that less than 90 percent of the tax was paid.

Example (a) — Failure to File

a. Tax due is $100.

b. Return filed 3 months and 10 days after the due date.

c. $100 paid with the return.

The calculation for additional tax due is shown below:

Tax	$100	
Penalty	10	(10% failure to timely file)
Interest	4	(4 months interest)
Total	$114	
Less payment	100	
Additional tax due	$ 14	

Example (b) — Failure to Pay

a. Tax due is $100.
b. Return is timely filed.
c. $0 paid.

The calculation for the total amount due 5 months after the due date is shown below:

Tax	$100	
Penalty	5	
Interest	5	(5 months interest)
Total	$110	

Example (c) — Failure to File and Failure to Pay

a. Tax due is $100.
b. Return is filed 2 months and 10 days after the due date.
c. $0 paid.

The calculation for the total amount due 3 months after the due date is shown below:

Tax	$100	
Penalty	10	(10% for failure to file)
Interest	3	(3 months interest)
Total due in 3rd month	$113	

Example (d) — Audit on Timely Filed Return

a. $100 in additional tax found due.
b. Timely filed return.
c. Audit completed 8 months after the due date of the return.
d. Return showed $100 as the computed tax, which was paid with the return.

The calculation for the total amount due is shown below:

Computed tax after audit	$200	
Less tax paid with return	100	
Additional tax due	$100	
Penalty	5	(5% for audit deficiency)
Interest	8	(8 months interest)
Total due	$113	

Example (e) — Audit on Late Return Granted an Exception From Failure to File

a. Tax due is $100.
b. Return filed 3 months and 10 days after the due date.
c. $100 paid with the return.
d. Taxpayer is granted an exception from penalty for failure to file. (Return is then considered timely filed.)

e. Audit completed 8 months after the due date of the return. $100 additional tax found due.
f. Return showed $100 as the computed tax which was paid with the return.
The computation for the total amount due is shown below:

Computed tax after audit	$200	
Less tax paid with return	100	
Additional tax due	$100	
Penalty	5	(5% for audit deficiency. No penalty for failure to file.)
Interest	8	(8 months interest)
Total due	$113	

Example (f) — Audit on Late Filed Return No Pay Return
a. $100 claimed as tax on the return.
b. $100 in additional tax found due.
c. Return filed 3 months and 10 days after the due date.
d. Audit completed 8 months after the due date.
The computation for the total amount due is shown below:

Computed tax after audit	$200	
Penalty	20	(10% for failure to file)
Interest	16	(8 months interest)
Total due	$236	

701—10.7(421) Waiver of penalty—definitions. A penalty, if assessed, shall be waived by the department upon a showing of the circumstances stated below.

10.7(1) For purposes of these rules, the following definitions apply:

"Act of God" means an unusual and extraordinary manifestation of nature which could not reasonably be anticipated or foreseen and cannot be prevented by human care, skill, or foresight. There is a rebuttable presumption that an "act of God" that precedes the due date of the return or form by 30 days is not an act of God for purposes of an exception to penalty.

"Immediate family" includes the spouse, children, or parents of the taxpayer. There is a rebuttable presumption that relatives of the taxpayer beyond the relation of spouse, children, or parents of the taxpayer are not within the taxpayer's immediate family for purposes of the waiver exceptions.

"Sanctioned self-audit program" means an audit performed by the taxpayer with forms provided by the department as a result of contact by the department to the taxpayer prior to voluntary filing or payment of the tax. Filing voluntarily without contact by the department does not constitute a sanctioned self-audit.

"Serious, long-term illness or hospitalization" means an illness or hospitalization, documented by written evidence, which precedes the due date of the return or form by no later than 30 days and continues through the due date of the return or form and interferes with the timely filing of the return or form. There is a rebuttable presumption that an illness or hospitalization that precedes the due date of the return or form by more than 30 days is not an illness or hospitalization for purposes of an exception to penalty. The taxpayer will be provided an automatic extension of 30 days from the date the return or form is originally due or the termination of the serious, long-term illness or hospitalization whichever is later without incurring penalty. The taxpayer has the burden of proof on whether or not a serious, long-term illness or hospitalization has occurred.

"Substantial authority" means the weight of authorities for the tax treatment of an item is substantial in relation to the weight of authorities supporting contrary positions.

In determining whether there is substantial authority, only the following will be considered authority: applicable provisions of Iowa statutes; the Internal Revenue Code; Iowa administrative rules construing those statutes; court cases; administrative rulings; legal periodicals; department newsletters

and tax return and deposit form instruction booklets; tax treaties and regulations; and legislative intent as reflected in committee reports.

Conclusions reached in treaties, legal opinions rendered by other tax professionals, descriptions of statutes prepared by legislative staff, legal counsel memoranda, and proposed rules and regulations are not authority.

There is substantial authority for the tax treatment of an item if there is substantial authority at the time the return containing the item is due to be filed or there was substantial authority on the last day of the taxable year to which the return relates.

The taxpayer must notify the department at the time the return, deposit form, or payment is originally due of the substantial authority the taxpayer is relying upon for not filing the return or deposit form or paying the tax due.

10.7(2) Reserved.

701—10.8(421) Penalty exceptions. Under certain circumstances the penalty for failure to timely file a return or deposit, failure to timely pay the tax shown due, or the tax required to be shown due with the filing of a return or a deposit form, or failure to pay following an audit by the department is waived.

When an exception is granted under subrule 10.9(1), the return or deposit form is considered timely filed for purposes of nonimposition of penalty only.

10.8(1) For failure to timely file a return or deposit form, the 10 percent penalty is waived upon a showing of the following exceptions:

a. At least 90 percent of the tax required to be shown due has been paid by the due date of the tax return or deposit form.

b. One late return allowed. A taxpayer required to file a return or deposit form quarterly, monthly, or semimonthly is allowed one untimely filed return or deposit form within a three-year period. The use by the taxpayer of any other penalty exception under this subrule will not count as a late return or deposit form for purposes of this subrule.

The exception for one late return in a three-year period is determined on the basis of the tax period for which the return or form is due and not the date on which the return is filed.

c. Death of a taxpayer, member of the immediate family of the taxpayer, or death of the person directly responsible for filing the return and paying the tax, when the death interferes with timely filing. There is a rebuttable presumption that a death which occurs more than 30 days before the original date the return or form is due does not interfere with timely filing.

d. The onset of serious, long-term illness or hospitalization of the taxpayer, a member of the taxpayer's immediate family, or the person directly responsible for filing the return and paying the tax.

e. Destruction of records by fire, flood, or act of God.

f. The taxpayer presents proof that the taxpayer at the due date of the return, deposit form, or payment relied upon applicable, documented, written advice made specifically to the taxpayer, the taxpayer's preparer, or to an association representative of the taxpayer from the department, state department of transportation, county treasurer, or federal Internal Revenue Service. The advice should be relevant to the agency offering the advice and not beyond the scope of the agency's area of expertise and knowledge. The advice must be current and not superseded by a court decision, ruling of a quasi-judicial body such as an administrative law judge, the director, or the state board of tax review, or by the adoption, amendment, or repeal of a rule or law.

g. Reliance upon the results of a previous audit was a direct cause for failure to file or pay where the previous audit expressly and clearly addressed the issue and the previous audit results have not been superseded by a court decision or by adoption, amendment, or repeal of a rule or law.

h. The taxpayer presents documented proof of substantial authority to rely upon a particular position or upon proof that all facts and circumstances are disclosed on a return or deposit form. Mathematical, computation, or transposition errors are not considered as facts and circumstances disclosed on a return or deposit form. These types of errors will not be considered as penalty exceptions.

i. The return, deposit form, or payment is timely, but erroneously, mailed with adequate postage to the Internal Revenue Service, another state agency, or a local government agency and the taxpayer

provides proof of timely mailing with adequate postage. The taxpayer must provide competent evidence of the mailing as stated in Iowa Code section 622.105.

j. The tax has been paid by the wrong licensee and the payments were timely remitted to the department for one or more tax periods prior to notification by the department.

k. The failure to file was discovered through a sanctioned self-audit program conducted by the department.

l. Effective for estates with disclaimers filed on or after July 1, 2007, penalty will not be imposed for a late-filed Iowa inheritance tax return if the sole reason for the late-filed inheritance tax return is due to a beneficiary's decision to disclaim property or disclaim an interest in property from the estate. However, for the penalty to be waived, the Iowa inheritance tax return must be filed and all tax must be paid to the department within the later of nine months from the date of death or 60 days from the delivery or filing date of the disclaimer pursuant to Iowa Code section 633E.12.

10.8(2) For failure to timely pay the tax due on a return or deposit form, the 5 percent penalty is waived upon a showing of the following exceptions:

a. At least 90 percent of the tax required to be shown due has been paid by the due date of the tax return or deposit form.

b. The taxpayer voluntarily files an amended return and pays all tax shown to be due on the return prior to any contact by the department, except under a sanctioned self-audit program conducted by the department.

c. The taxpayer provides written notification to the department of a federal audit while it is in progress and voluntarily files an amended return which includes a copy of the federal document showing the final disposition or final federal adjustments within 60 days of the final disposition of the federal government's audit.

d. The taxpayer presents proof that the taxpayer relied upon applicable, documented, written advice specifically made to the taxpayer, to the taxpayer's preparer, or to an association representative of the taxpayer from the department, state department of transportation, county treasurer, or federal Internal Revenue Service, whichever is appropriate, that has not been superseded by a court decision, ruling by a quasi-judicial body, or the adoption, amendment, or repeal of a rule or law.

e. Reliance upon results in a previous audit was a direct cause for the failure to pay the tax required to be shown due where the previous audit expressly and clearly addressed the issue and the previous audit results have not been superseded by a court decision, or the adoption, amendment, or repeal of a rule or law.

f. The taxpayer presents documented proof of substantial authority to rely upon a particular position or upon proof that all facts and circumstances are disclosed on a return or deposit form. Mathematical, computation, or transposition errors are not considered as facts and circumstances disclosed on a return or deposit form. These types of errors will not be considered as penalty exceptions.

g. The return, deposit form, or payment is timely, but erroneously, mailed with adequate postage to the Internal Revenue Service, another state agency, or a local government agency and the taxpayer provides proof of timely mailing with adequate postage. The taxpayer must provide competent evidence of the mailing as stated in Iowa Code section 622.105.

h. The tax has been paid by the wrong licensee and the payments were timely remitted to the department for one or more tax periods prior to notification by the department.

i. Effective for estates with disclaimers filed on or after July 1, 2007, penalty will not be imposed for failure to pay Iowa inheritance tax if the sole reason for the failure to pay Iowa inheritance tax is due to a beneficiary's decision to disclaim property or disclaim an interest in property from the estate. However, for the penalty to be waived, the Iowa inheritance tax return must be filed and all tax must be paid to the department within the later of nine months from the date of death or 60 days from the filing date of the disclaimer pursuant to Iowa Code section 633E.12.

10.8(3) For a deficiency of tax due on a return or deposit form found during an audit, the 5 percent penalty is waived under the following exceptions:

a. At least 90 percent of the tax required to be shown due has been paid by the due date.

b. The taxpayer presents proof that the taxpayer relied upon applicable, documented, written advice specifically made to the taxpayer, to the taxpayer's preparer, or to an association representative of the taxpayer from the department, state department of transportation, county treasurer, or federal Internal Revenue Service, whichever is appropriate, that has not been superseded by a court decision, ruling by a quasi-judicial body, or the adoption, amendment, or repeal of a rule or law.

c. Reliance upon results in a previous audit was a direct cause for the failure to pay the tax shown due or required to be shown due where the previous audit expressly and clearly addressed the issue and the previous audit results have not been superseded by a court decision, or the adoption, amendment, or repeal of a rule or law.

d. The taxpayer presents documented proof of substantial authority to rely upon a particular position or upon proof that all facts and circumstances are disclosed on a return or deposit form. Mathematical, computation, or transposition errors are not considered as facts and circumstances disclosed on a return or deposit form. These types of errors will not be considered as penalty exceptions.
[**ARC 7761B**, IAB 5/6/09, effective 6/10/09]

701—10.9(421) Notice of penalty exception for one late return in a three-year period. The penalty exception for one late return in a three-year period will automatically be applied to a return or deposit form by the department if the taxpayer is eligible for the exception.

The exception for one late return in a three-year period is applied to the returns or deposit forms in the order they are processed and not in the order which the returns or deposit forms should have been filed.

701—10.10 to **10.19** Reserved.

RETAIL SALES
[Prior to 1/23/91, see 701—12.10(422,423) and 12.11(422, 423)]

701—10.20(422,423) Penalty and interest computation. Rescinded IAB 5/6/09, effective 6/10/09.

701—10.21(422,423) Request for waiver of penalty. Rescinded IAB 5/6/09, effective 6/10/09.

701—10.22 to **10.29** Reserved.

USE
[Prior to 1/23/91, see 701—30.10(423)]

701—10.30(423) Penalties for late filing of a monthly tax deposit or use tax returns. Rescinded IAB 5/6/09, effective 6/10/09.

701—10.31 to **10.39** Reserved.

INDIVIDUAL INCOME
[Prior to 1/23/91, see 44.1(422), 44.3(422), 44.7(422) and 44.8(422)]

701—10.40(422) General rule. Rescinded IAB 11/24/04, effective 12/29/04.

701—10.41(422) Computation for tax payments due on or after January 1, 1981, but before January 1, 1982. Rescinded IAB 11/24/04, effective 12/29/04.

701—10.42(422) Interest commencing on or after January 1, 1982. Rescinded IAB 11/24/04, effective 12/29/04.

701—10.43(422) Request for waiver of penalty. Rescinded IAB 11/24/04, effective 12/29/04.

701—10.44 to **10.49** Reserved.

WITHHOLDING
[Prior to 1/23/91, see 701—46.5(422)]

701—10.50(422) Penalty and interest. Rescinded IAB 11/24/04, effective 12/29/04.

701—10.51 to **10.55** Reserved.

CORPORATE
[Prior to 1/23/91, see subrule 701—52.5(3) and rule 701—52.10(422)]

701—10.56(422) and **10.57(422) Penalty and interest.** Rescinded IAB 11/24/04, effective 12/29/04.

701—10.58(422) Waiver of penalty and interest. Rescinded IAB 11/24/04, effective 12/29/04.

701—10.59 to **10.65** Reserved.

FINANCIAL INSTITUTIONS
[Prior to 1/23/91, see 701—58.6(422)]

701—10.66(422) Penalty and interest. Rescinded IAB 11/24/04, effective 12/29/04.

701—10.67 to **10.70** Reserved.

MOTOR FUEL
[Prior to 1/23/91, see 701—63.8(324) and 63.10(324)]

701—10.71(452A) Penalty and enforcement provisions.

10.71(1) *Illegal use of dyed fuel.* The illegal use of dyed fuel in the supply tank of a motor vehicle shall result in a civil penalty assessed against the owner or operator of the motor vehicle as follows:

a. A $500 penalty for the first violation.

b. A $1,000 penalty for a second violation within three years of the first violation.

c. A $2,000 penalty for third and subsequent violations within three years of the first violation.

10.71(2) *Illegal importation of untaxed fuel.* A person who illegally imports motor fuel or undyed special fuel without a valid importer's license or supplier's license shall be assessed a civil penalty as stated below. However, the owner or operator of the importing vehicle shall not be guilty of violating the illegal import provision if it is shown by the owner or operator that the owner or operator reasonably did not know or reasonably should not have known of the illegal importation.

a. For a first violation, the importing vehicle shall be detained and a penalty of $4,000 shall be paid before the vehicle will be released. The owner or operator of the importing vehicle or the owner of the fuel may be held liable for payment of the penalty.

b. For a second violation, the importing vehicle shall be detained and a penalty of $10,000 shall be paid before the vehicle will be released. The owner or operator of the importing vehicle or the owner of the fuel may be held liable to pay the penalty.

c. For third and subsequent violations, the importing vehicle and the fuel shall be seized and a penalty of $20,000 shall be paid before the vehicle will be released. The owner or operator of the importing vehicle or the owner of the fuel may be held liable to pay the penalty.

d. If the owner or operator of the importing vehicle or the owner of the fuel fails to pay the tax and penalty for a first or second offense, the importing vehicle and the fuel may be seized. The Iowa department of revenue, the Iowa department of transportation, or any peace officer, at the request of either department, may seize the vehicle and the fuel.

e. If the operator or owner of the importing vehicle or the owner of the fuel moves the vehicle or the fuel after the vehicle has been detained and a sticker has been placed on the vehicle stating that "this vehicle cannot be moved until the tax, penalty, and interest have been paid to the department of revenue," an additional penalty of $10,000 shall be assessed against the operator or owner of the importing vehicle or the owner of the fuel.

10.71(3) *Improper receipt of fuel credit or refund.* If a person files an incorrect refund claim, in addition to the amount of the excess claim, a penalty of 10 percent shall be added to the amount by which the amount claimed and refunded exceeds the amount actually due and shall be paid to the department. If a person knowingly files a fraudulent refund claim with the intent to evade the tax, the penalty shall be 75 percent in lieu of the 10 percent. The person shall also pay interest on the excess refunded at the rate per month specified in Iowa Code section 421.7, counting each fraction of a month as an entire month, computed from the date the refund was issued to the date the excess refund is repaid to the state.

10.71(4) *Illegal heating of fuel.* The deliberate heating of taxable motor fuel or special fuel by dealers prior to consumer sale is a simple misdemeanor.

10.71(5) *Prevention of inspection.* The Iowa department of revenue or the Iowa department of transportation may conduct inspections for coloration, markers, and shipping papers at any place where taxable fuel is or may be loaded into transport vehicles, produced, or stored. Any attempts by a person to prevent, stop, or delay an inspection of fuel or shipping papers by authorized personnel shall be subject to a civil penalty of not more than $2,000 per occurrence. Any law enforcement officer requested by the Iowa department of revenue or Iowa department of transportation may physically inspect, examine, or otherwise search any tank, fuel supply tank of a vehicle, reservoir, or other container that can or may be used for the production, storage, or transportation of any type of fuel.

10.71(6) *Failure to conspicuously label a fuel pump.* A retailer who does not conspicuously label a pump or other delivery facility as required by the Internal Revenue Service, that dispenses dyed diesel fuel so as to notify customers that it contains dyed fuel, shall pay to the department of revenue a penalty of $100 per occurrence.

10.71(7) *False or fraudulent return.* Any person, including an officer of a corporation or a manager of a limited liability company, who is required to make, render, sign, or verify any report or return required by this chapter and who makes a false or fraudulent report, or who fails to file a report or return with the intent to evade the tax, shall be guilty of a fraudulent practice. Any person who aids, abets, or assists another person in making any false or fraudulent return or false statement in any return with the intent to evade payment of tax shall be guilty of a fraudulent practice.

This rule is intended to implement Iowa Code section 452A.74A as amended by 2009 Iowa Acts, Senate File 478, section 141.

[**ARC 8225B**, IAB 10/7/09, effective 11/11/09]

701—10.72(452A) Interest. Interest at the rate of three-fourths of one percent per month, based on the tax due, shall be assessed against the taxpayer for each month such tax remains unpaid prior to January 1, 1982. The interest shall accrue from the date the return was required to be filed. Interest shall not apply to penalty. Each fraction of a month shall be considered a full month for the computation of interest. See rule 701—10.2(421) for the statutory interest rate commencing on or after January 1, 1982.

Refunds on reports or returns filed on or after July 1, 1986, but before July 1, 1997, will accrue interest beginning on the first day of the third calendar month following the date of payment or the date the return was filed or due to be filed, whichever is later, at the rate in effect under Iowa Code section 421.7, counting each fraction of a month as an entire month. Refunds on reports or returns filed on or after July 1, 1997, will accrue interest beginning on the first day of the second calendar month following the date of payment or the date the return was filed or due to be filed, whichever is later. Claims for refund filed under Iowa Code sections 452A.17 and 452A.21 will accrue interest beginning with the first day of the second calendar month following the date the refund claim is received by the department. See rule 10.3(422,450,452A).

This rule is intended to implement Iowa Code section 452A.65 as amended by 1997 Iowa Acts, House File 266.

701—10.73 to **10.75** Reserved.

CIGARETTES AND TOBACCO
[Prior to 1/23/91, see 701—81.8(98), 81.9(98), and 81.15(98)]

701—10.76(453A) Penalties.

10.76(1) *Cigarettes.* The following is a list of offenses which subject the violator to a penalty:

1. The failure of a permit holder to maintain proper records;
2. The sale of taxable cigarettes without a permit;
3. The filing of a late, false or incomplete report with the intent to evade tax by a cigarette distributor, distributing agent or wholesaler;
4. Acting as a distributing agent without a valid permit; and
5. A violation of any provision of Iowa Code chapter 453A or these rules.

Penalties for these offenses are as follows:

- A $200 penalty for the first violation.
- A $500 penalty for a second violation within three years of the first violation.
- A $1,000 penalty for a third or subsequent violation within three years of the first violation.

Penalties for possession of unstamped cigarettes are as follows:

- A $200 penalty for the first violation if a person is in possession of more than 40 but not more than 400 unstamped cigarettes.
- A $500 penalty for the first violation if a person is in possession of more than 400 but not more than 2,000 unstamped cigarettes.
- A $1,000 penalty for the first violation if a person is in possession of more than 2,000 unstamped cigarettes for violations occurring prior to July 1, 2004. A $25 per pack penalty for the first violation if a person is in possession of more than 2,000 unstamped cigarettes for violations occurring on or after July 1, 2004.
- For a second violation within three years of the first violation, the penalty is $400 if a person is in possession of more than 40 but not more than 400 unstamped cigarettes; $1,000 if a person is in possession of more than 400 but not more than 2,000 unstamped cigarettes; and $2,000 if a person is in possession of more than 2,000 unstamped cigarettes for violations occurring prior to July 1, 2004. A $35 per pack penalty applies if a person is in possession of more than 2,000 unstamped cigarettes for violations occurring on or after July 1, 2004.
- For a third or subsequent violation within three years of the first violation, the penalty is $600 if a person is in possession of more than 40 but not more than 400 unstamped cigarettes; $1,500 if a person is in possession of more than 400 but not more than 2,000 unstamped cigarettes; and $3,000 if a person is in possession of more than 2,000 unstamped cigarettes for violations occurring prior to July 1, 2004. A $45 per pack penalty applies if a person is in possession of more than 2,000 unstamped cigarettes for violations occurring on or after July 1, 2004.

See rule 701—10.6(421) for penalties related to failure to timely file a return, failure to timely pay the tax due, audit deficiency, and willful failure to file a return with the intent to evade the tax. If, upon audit, it is determined that any person has failed to pay at least 90 percent of the tax imposed by Iowa Code chapter 453A, division I, which failure was not the result of a violation enumerated above, a penalty of 5 percent of the tax deficiency shall be imposed. This penalty is not subject to waiver for reasonable cause.

See rule 701—10.8(421) for statutory exceptions to penalty.

10.76(2) *Tobacco.*

See rule 701—10.6(421) for penalties related to failure to timely file a return, failure to timely pay the tax due, audit deficiency, and willful failure to file a return with the intent to evade the tax.

See rule 701—10.8(421) for statutory exceptions to penalty.

This rule is intended to implement Iowa Code sections 453A.28, 453A.31 and 453A.46 as amended by 2004 Iowa Acts, Senate File 2296.

701—10.77(453A) Interest.

10.77(1) *Cigarettes.* There shall be assessed interest at the rate established by rule 701—10.2(421) from the due date of the tax to the date of payment counting each fraction of a month as an entire month. For the purpose of computing the due date of any unpaid tax, a FIFO inventory method shall be used for cigarettes and stamps. See rule 701—10.6(421) for examples of penalty and interest.

10.77(2) *Tobacco.* The interest rate on delinquent tobacco tax is the rate established by rule 701—10.2(421) counting each fraction of a month as an entire month. If an assessment for taxes due is not allocated to any given month, the interest shall accrue from the date of assessment. See rule 701—10.6(421) for examples of penalty and interest.

This rule is intended to implement Iowa Code sections 453A.28 and 453A.46.

701—10.78(453A) Waiver of penalty or interest. Rescinded IAB 11/10/04, effective 12/15/04.

701—10.79(453A) Request for statutory exception to penalty. Any taxpayer who believes there is a good reason to object to any penalty imposed by the department for failure to timely file returns or pay the tax may submit a request for exception seeking that the penalty be waived. The request must be in the form of a letter or affidavit and must contain all facts alleged by the taxpayer and a reason for why the taxpayer qualifies for the exceptions. See rule 701—10.8(421).

This rule is intended to implement Iowa Code sections 453A.31 and 453A.46.

701—10.80 to **10.84** Reserved.

INHERITANCE
[Prior to 1/23/91, see 701—subrules 86.2(14) to 86.2(20)]

701—10.85(422) Penalty—delinquent returns and payment. Rescinded IAB 5/6/09, effective 6/10/09.

701—10.86 to **10.89** Reserved.

IOWA ESTATE
[Prior to 1/23/91, see 701—subrules 87.3(9) to 87.3(12)]

701—10.90(451) Penalty—delinquent return and payment. Rescinded IAB 5/6/09, effective 6/10/09.

701—10.91 to **10.95** Reserved.

GENERATION SKIPPING
[Prior to 1/23/91, see 701—subrules 88.3(14) and 88.3(15)]

701—10.96(450A) Penalty—delinquent return and payment for deaths occurring before January 1, 1991. Rescinded IAB 5/6/09, effective 6/10/09.

701—10.97(422) Interest on tax due. Rescinded IAB 5/6/09, effective 6/10/09.

701—10.98 to **10.100** Reserved.

FIDUCIARY INCOME
[Prior to 1/23/91, see 701—89.6(422) and 89.7(422)]

701—10.101(422) Penalties. Rescinded IAB 5/6/09, effective 6/10/09.

701—10.102(422) Penalty. Rescinded IAB 5/6/09, effective 6/10/09.

701—10.103(422) Interest on unpaid tax. Rescinded IAB 5/6/09, effective 6/10/09.

701—10.104 to **10.109** Reserved.

HOTEL AND MOTEL
[Prior to 1/23/91, see 701—104.8(422A) and 104.9(422A)]

701—10.110(423A) Interest and penalty. Rescinded IAB 5/6/09, effective 6/10/09.

701—10.111(423A) Request for waiver of penalty. Rescinded IAB 5/6/09, effective 6/10/09.

701—10.112 to **10.114** Reserved.

ALL TAXES

701—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. The department will not reapply prior payments made by the taxpayer to penalty or interest determined to be due after the date of those prior payments. However, the department will apply payments to penalty and interest which were due at the time the payment was made.

Example (a) — Delinquent Return

a. Tax due is $1,000.

b. Return filed two months late.

c. $1,000 paid with the return.

d. The department bills the additional tax in the third month after the due date. The taxpayer pays the assessment in the third month.

The computation of additional tax is shown below:

Tax	$1,000.00	
Penalty	100.00	(10% failure to file penalty)
Interest	14.00	(2 months interest)
Total	$1,114.00	
Less payment	1,000.00	
Additional tax due	$ 114.00	
Interest	.80	(1 month interest)
Total due	$ 114.80	

Two years after the due date, the Internal Revenue Service conducts an audit and increases the taxpayer's taxable income. The department redetermines the taxpayer's liability 26 months after the due date as follows:

Tax as redetermined by the department	$1,100.00	
Less paid with return	1,000.00	
Additional tax	$ 100.00	
Penalty	10.00	(10% failure to file penalty)
Interest	18.20	(26 months interest)
Total due	$ 128.20	

Example (b) — Timely Filed No Remit

a. Tax due is $1,000.

b. Return timely filed.

c. $0 paid.

The calculation for the total amount due five months after the due date is shown below:

Tax	$1,000.00	
Penalty	50.00	(5% failure to pay penalty)
Interest	35.00	(5 months interest)
Total due	$1,085.00	

The department bills the additional tax in the fifth month after the due date and the taxpayer pays the additional amount in the eighth month after the due date. The payment is applied as follows:

Tax	$1,000.00	
Penalty	50.00	(5% failure to pay penalty)
Interest	56.00	(8 months interest)
Total due	$1,106.00	
Amount paid	$1,085.00	

Balance tax due $21.00 subject to interest until paid.

The balance due was not paid.

Three years after the due date the taxpayer forwards a copy of an Internal Revenue Service audit which increases the taxpayer's income to the department. The department recomputes the taxpayer's liability as follows:

Tax as redetermined by the department	$1,200.00	
Less paid per prior audit	979.00	
Balance due	$ 221.00	(includes the balance due of $21)
Penalty	10.00	(5% failure to pay penalty on $200, the $21.00 already bears penalty)
Interest	54.52	(36 months interest on $200 and 28 months interest on $21)
Total due	$ 285.52	

10.115(1) *Refunds.* In those instances where an audit reduced the amount of tax, penalty, and interest due over the amount paid, the department will reapply payments so that amount refunded is tax on which interest will accrue as set forth in the Iowa Code.

10.115(2) *Partial payments made after notices of assessments are issued.* Where partial payments are made after a notice of assessment is issued, the department will reapply payments to penalty, interest, and then to tax due until the entire assessed amount is paid. See *Ashland Oil Inc. v. Iowa Department of Revenue and Finance*, 452 N.W.2d 162 (Iowa 1990). If penalty, interest, and tax are due and owing for more than one tax period, any payment must be applied first to the penalty, then the interest, then the tax for the oldest tax period, then to the penalty, interest, and tax to the next oldest tax period, and so on until the payment is exhausted.

Where there are both agreed- and unagreed-to items as a result of an examination, the taxpayer and the department may agree to apply payments to the penalty, interest, and then to tax due on the agreed-to items of the examination when all of the penalty, interest, and tax on the agreed-to items are paid. In these instances, subsequent payments will not be applied to penalty and interest accrued on the agreed-to items of the examination.

This rule is intended to implement Iowa Code section 422.25(4).

[**ARC 7761B**, IAB 5/6/09, effective 6/10/09]

JEOPARDY ASSESSMENTS

701—10.116(422,453B) Jeopardy assessments. A jeopardy assessment may be made where a return has been filed and the director believes for any reason that assessment or collection of the tax will be jeopardized by delay, or where a taxpayer fails to file a return, whether or not formally called upon to file a return. In addition, all assessments made pursuant to Iowa Code chapter 453B are jeopardy assessments. The department is authorized to estimate the applicable tax base and the tax upon the basis of available information, add penalty and interest, and demand immediate payment.

A jeopardy assessment is due and payable when the notice of the assessment is served upon the taxpayer. Proceedings to enforce the payment of the assessment by seizure or sale of any property of the taxpayer may be instituted immediately.

This rule is intended to implement Iowa Code sections 422.30 and 453B.9.

701—10.117(422,453B) Procedure for posting bond. In the event a taxpayer seeks to post a bond in lieu of summary collection of a jeopardy assessment, pending final determination of the amount of tax legally due, an original and four copies of a separate written bond application conspicuously titled "Jeopardy Assessment Bond Request" must be filed with the clerk of the hearings section for the department. Thereafter, if the taxpayer and the department agree on an appropriate bond, the clerk of the hearings section for the department shall be notified and the bond shall be approved by the clerk of the hearings section for the department.

If the clerk of the hearings section for the department has not been notified that an agreement on the bond has been reached within ten days after the date upon which the bond request was filed, the clerk of the hearings section for the department shall transfer the file to the director who shall promptly schedule a hearing on the bond request with written notice to be given the taxpayer and the department at least ten days prior to the hearing.

This rule is intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202, and sections 422.30 and 453B.9.

701—10.118(422,453B) Time limits. Bond requests may be made anytime after a timely protest to the jeopardy assessment has been filed with the clerk of the hearings section for the department, except that any bond request whereby the taxpayer seeks to postpone a scheduled sale of assets seized by or on behalf of the department must be filed with the clerk of the hearings section for the department no later than ten days from the date on which notice of the sale was mailed to, or otherwise served upon, the taxpayer. Portions of an assessment which are undisputed must be paid in full at the time a bond request is filed.

This rule is intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202, and sections 422.30 and 453B.9.

701—10.119(422,453B) Amount of bond. In the event no agreement on the bond is reached, bonds must be posted in an amount to be determined by the director consistent with the following:

10.119(1) If property has been seized or a lien has been filed and the taxpayer seeks only to postpone the sale of property, pending final determination of the amount of tax legally due, the bond shall be in an amount equal to the expected depreciation loss, storage cost, insurance costs and any and all other costs associated with the distraint and storage of the property pending such final determination.

10.119(2) If property has been seized or a lien has been filed and the taxpayer seeks to prevent the sale of property and to have the property returned for the taxpayer's own use, pending final determination of the amount of tax legally due, the bond shall be in an amount equal to the sale price the department can reasonably expect to realize on any property seized plus all costs related to the distraint and storage of the property.

10.119(3) If a taxpayer seeks to prevent the department from seizing property or placing a lien upon property, pending final determination of the amount of tax legally due, the bond shall be in an amount equal to the total amount of the department's assessment including interest to the date of the bond.

Bonds may not be required in excess of double the amount of the department's jeopardy assessment.

This rule is intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202, and sections 422.30 and 453B.9.

701—10.120(422,453B) Posting of bond. If the taxpayer fails to post the bond as agreed upon within 15 days from the date the bond is approved by the clerk of the hearings section for the department, no bond will be allowed and the director shall dismiss the bond request. If no agreement was reached and a bond order is issued by the director, the taxpayer has ten days to post the bond. If the bond is not posted within the ten-day period, the director shall dismiss the bond request.

This rule is intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202, and sections 422.30 and 453B.9.

701—10.121(422,453B) Order. The director's order shall be in writing and shall include findings of fact based solely on the evidence in the record and on matters officially noticed in the record and shall include conclusions of law. The findings of fact and conclusions of law shall be separately stated. Findings of fact shall be prefaced by a concise and explicit statement of underlying facts supporting the findings. Each conclusion of law shall be supported by cited authority or by a reasoned opinion.

Orders will be issued within a reasonable time after termination of the hearing. Parties shall be promptly notified of each order by delivery to them of a copy of the order by personal service or by ordinary mail.

This rule is intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202, and sections 422.30 and 453B.9.

701—10.122(422,453B) Director's order. The director's order constitutes the final order of the department for purposes of judicial review. Parties shall be promptly notified of the director's order by delivery to them of a copy of the order by personal service or by ordinary mail.

This rule is intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202, and sections 422.30 and 453B.9.

701—10.123(422,453B) Type of bond. The bond shall be payable to the department for the use of the state of Iowa and shall be conditioned upon the full payment of the tax, penalty, interest, or fees that are found to be due which remain unpaid upon the resolution of the contested case proceedings up to the amount of the bond. Upon application of the taxpayer or the department, the director may, upon hearing, fix a greater or lesser amount to reflect changed circumstances, but only after ten days' prior notice is given to the department or the taxpayer as the case may be.

A personal bond, without a surety, is only permitted if the taxpayer posts with the clerk of the hearings section for the department, cash, a cashier's check, a certificate of deposit, or other marketable securities which are approved by the director with a readily ascertainable value which is equal in value to the total amount of the bond required. If a surety bond is posted, the surety on the bond may be either personal or corporate. The provisions of Iowa Code chapter 636 relating to personal and corporate sureties shall govern to the extent not inconsistent with the provisions of this subrule.

This rule is intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202, and sections 422.30 and 453B.9.

701—10.124(422,453B) Form of surety bond. The surety bond posted shall be in substantially the following form:

BEFORE THE IOWA STATE DEPARTMENT OF REVENUE
HOOVER STATE OFFICE BUILDING
DES MOINES, IOWA

IN THE MATTER OF	*	
	*	
(Taxpayer's Name, Address and	*	SURETY BOND
designate proceeding, e.g.,	*	
income, sales, etc.)	*	DOCKET NO.
	*	

KNOW ALL PERSONS BY THESE PRESENTS:

That we _____(taxpayer)_____ as principal, and _____(surety)_____, as surety, of the county of _____, and State of Iowa, are held and firmly bound unto the Iowa Department of Revenue for the use of the State of Iowa, in the sum of $ _____ dollars, lawful money of the United States, for the payment of which sum we jointly and severally bind ourselves, our heirs, devisees, successors and assigns firmly by these presents. The condition of the foregoing obligations are, that, whereas the above-named principal has protested an assessment of tax, penalty, interest, or fees or any combination of them, made by the Iowa Department of Revenue, now if the principal _____ shall promptly pay the amount of the assessed tax, penalty, interest or fees found to be due upon the resolution of the contested case proceedings, then this bond shall be void, otherwise to remain in full force and effect.

Dated this _____ day of _____, _____.

_____
Principal

_____
Surety

_____
Surety
(corporate acknowledgment if surety is a corporation)

AFFIDAVIT OF PERSONAL SURETY

STATE OF IOWA)
ss
COUNTY OF)

I hereby swear or affirm that I am a resident of Iowa and am worth beyond my debts the amount set opposite my signature below in the column entitled, "Worth Beyond Debts," and that I have property in the State of Iowa, liable to execution equal to the amount set opposite my signature in the column entitled "Property in Iowa Liable to Execution."

Signature	Worth Beyond Debts	Property in Iowa Liable to Execution
_____	$ _____	$ _____
Surety (type name)		
_____	$ _____	$ _____
Surety (type name)		

Subscribed and sworn to before me the undersigned Notary Public this _____ day of _____, _____.

(Seal) Notary Public in and for the State of Iowa

701—10.125(422,453B) Duration of the bond. The bond shall remain in full force and effect until the conditions of the bond have been fulfilled or until the bond is otherwise exonerated as provided by law.

This rule is intended to implement Iowa Code sections 422.30 and 453B.9.

701—10.126(422,453B) Exoneration of the bond. Upon conclusion of the contested case administrative proceedings, the bond shall be exonerated by the director when any of the following events occur: upon full payment of the tax, penalty, interest, costs or fees found to be due; upon filing a bond for the purposes of judicial review which bond is sufficient to secure the unpaid tax penalty, interest, costs and fees; or if no additional tax, penalty, interest, costs or fees are found to be due that have not been previously paid, upon entry of a final unappealable order which resolves the underlying protest.

This rule is intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202, and sections 422.30 and 453B.9.

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