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The Iowa Administrative Code Supplement is published biweekly pursuant to Iowa Code section 17A.6. The Supplement contains replacement pages to be inserted in the loose-leaf Iowa Administrative Code (IAC) according to instructions included with each Supplement. The replacement pages 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 pages 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(4); an effective date delay imposed by the ARRC pursuant to section 17A.4(5) or 17A.8(9); rescission of a rule by the Governor pursuant to section 17A.4(6); 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 and for the preliminary sections of the IAC: General Information about the IAC, Chapter 17A of the Code of Iowa, Style and Format of Rules, Table of Rules Implementing Statutes, and Uniform Rules on Agency Procedure.

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g. (1) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed 24 months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of such policy or certificate within 90 days after the date the individual becomes entitled to such assistance.

(2) If such suspension occurs and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstituted (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the policyholder or certificate holder provides notice of loss of such entitlement within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

(3) Reinstitution of such coverages:

1. Shall not provide for any waiting period with respect to treatment of preexisting conditions;
2. Shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension; and
3. Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(4) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended for the period provided by federal regulation at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan as defined in Section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted effective as of the date of loss of coverage if the policyholder provides notice of loss of coverage within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

37.7(2) *Standards for Basic ("Core") Benefits Common to All Benefit Plans.* Every issuer shall make available a policy or certificate including only the following basic "Core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic "Core" package, but not in lieu thereof.

a. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period;

b. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

c. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A Eligible Expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days;

d. Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

e. Coverage for the coinsurance amount or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

37.7(3) *Standards for Additional Benefits.* The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by 37.8(514D).

a. Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

b. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

c. Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

d. Eighty percent of the Medicare Part B Excess Charges: Coverage for 80 percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

e. One hundred percent of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

f. Basic Outpatient Prescription Drug Benefit: Coverage for 50 percent of outpatient prescription drug charges, after a $250 calendar year deductible, to a maximum of $1,250 in benefits received by the insured per calendar year to the extent not covered by Medicare.

g. Extended Outpatient Prescription Drug Benefit: Coverage for 50 percent of outpatient prescription drug charges, after a $250 calendar year deductible to a maximum of $3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare.

h. Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250 and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

i. Preventive Medical Care Benefit: Coverage for the following preventive health services:

(1) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph (2) and patient education to address preventive health care measures.

(2) Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

1. Digital rectal examination;
2. Dipstick urinalysis for hematuria, bacteriuria and proteinuria;
3. Pure tone (air only) hearing screening test, administered or ordered by a physician;
4. Serum cholesterol screening (every five years);
5. Thyroid function test;
6. Diabetes screening;
7. Tetanus and diphtheria booster (every ten years).

(3) Any other tests or preventive measures determined appropriate by the attending physician.

Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

j. At-Home Recovery Benefit: Coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(1) For purposes of this benefit, the following definitions shall apply:

1. "Activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.
2. "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.
3. "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

4. "At-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24-hour period of services provided by a care provider is one visit.

(2) Coverage requirements and limitations.

1. At-home recovery services provided must be primarily services which assist in activities of daily living.

2. The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

3. Coverage is limited to:

- No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment.
- The actual charges for each visit up to a maximum reimbursement of $40 per visit.
- One thousand six hundred dollars per calendar year.
- Seven visits in any one week.
- Care furnished on a visiting basis in the insured's home.
- Services provided by a care provider as defined in this paragraph *"j."*
- At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.
- At-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare-approved home health care visit.

(3) Coverage is excluded for:

1. Home care visits paid for by Medicare or other government programs; and

2. Care provided by family members, unpaid volunteers or providers who are not care providers.

k. New or Innovative Benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. Such new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies.

191—37.8(514D) Standard Medicare supplement benefit plans.

37.8(1) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic "Core" benefits as defined in 37.7(2).

37.8(2) No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in 37.7(3)*"k"* and in 37.9(514D).

37.8(3) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "J" listed in this subrule and conform to the definitions in 37.3(514D). Each benefit shall be structured in accordance with the format provided in 37.7(2) and 37.7(3) and list the benefits in the order shown in this subrule. For purposes of this rule, "structure, language, and format" means style, arrangement and overall content of a benefit.

37.8(4) An issuer may use, in addition to the benefit plan designations required in 37.8(3), other designations to the extent permitted by law.

37.8(5) Makeup of benefit plans:

a. Standardized Medicare supplement benefit plan "A" shall be limited to the Basic ("Core") Benefits Common to All Benefit Plans, as defined in 37.7(2).

b. Standardized Medicare supplement benefit plan "B" shall include only the following: The Core Benefit as defined in 37.7(2), plus the Medicare Part A Deductible as defined in 37.7 (3)*"a."*

c. Standardized Medicare supplement benefit plan "C" shall include only the following: The Core Benefit as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible and Medically Necessary Emergency Care in a Foreign Country as defined in 37.7(3) *"a," "b," "c,"* and *"h,"* respectively.

d. Standardized Medicare supplement benefit plan "D" shall include only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and the At-Home Recovery Benefit as defined in 37.7(3) *"a," "b," "h,"* and *"j,"* respectively.

e. Standardized Medicare supplement benefit plan "E" shall include only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and Preventive Medical Care as defined in 37.7(3) *"a," "b," "h,"* and *"i,"* respectively.

f. Standardized Medicare supplement benefit plan "F" shall include only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, the Skilled Nursing Facility Care, the Part B Deductible, 100 Percent of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in 37.7(3) *"a," "b," "c," "e,"* and *"h,"* respectively.

g. Standardized Medicare supplement benefit plan "G" shall include only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, 80 Percent of the Medicare Part B Excess Charges, Medically Necessary Emergency Care in a Foreign Country, and the At-Home Recovery Benefit as defined in 37.7(3) *"a," "b," "d," "h,"* and *"j,"* respectively.

h. Standardized Medicare supplement benefit plan "H" shall consist of only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Prescription Drug Benefit and Medically Necessary Emergency Care in a Foreign Country as defined in 37.7(3) *"a," "b," "f,"* and *"h,"* respectively.

i. Standardized Medicare supplement benefit plan "I" shall consist of only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, 100 Percent of the Medicare Part B Excess Charges, Basic Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit as defined in 37.7(3)*"a," "b," "e," "f," "h,"* and *"j,"* respectively.

j. Standardized Medicare supplement benefit plan "J" shall consist of only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, 100 Percent of the Medicare Part B Excess Charges, Extended Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care and At-Home Recovery Benefit as defined in 37.7(3) *"a," "b," "c," "e," "g," "h," "i,"* and *"j,"* respectively.

191—37.24(514D) Guaranteed issue for eligible persons.

37.24(1) Eligible persons are those individuals described in subrule 37.24(2) who seek to enroll under the policy during the period specified in subrule 37.24(3) and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.

With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subrule 37.24(5) that is offered and is available for issuance to new enrollees by issuer, shall not discriminate in the pricing of such Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such Medicare supplement policy.

37.24(2) An eligible person is an individual described in any of the following paragraphs:

a. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement benefits under Medicare and the plan terminates or the plan ceases to provide some or all such supplemental health benefits to the individual;

b. The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under Part C of Medicare and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act and circumstances exist similar to those described below that would permit discontinuance of the individual's enrollment with such a provider if such individual were enrolled in a Medicare+Choice plan:

(1) The certification of the organization or plan under this part has been terminated; or

(2) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides; or

(3) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence area; or

(4) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

1. The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

2. The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(5) The individual meets such other exceptional conditions as the Secretary may provide;

c. The individual is enrolled with:

(1) An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost); or

(2) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999; or

(3) An organization operating under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care payment plan); or

(4) An organization under Medicare Select policy; and

(5) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph 37.24(2)"*b*";

d. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(1) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(2) The issuer of the policy substantially violated a material provision of the policy; or

(3) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

e. The individual was enrolled under a Medicare supplement policy and terminated enrollment and subsequently enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under Part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act, or a Medicare Select policy; and the subsequent enrollment under 37.24(2)*"e"* was terminated by the enrollee during any period within the first 12 months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act); or

f. The individual upon first becoming enrolled for benefits under Part B of Medicare at age 65 or older enrolls in a Medicare+Choice plan under Part C of Medicare or with a PACE provider under Section 1894 of the Social Security Act and disenrolls from the plan or program by no later than 12 months after the effective date of enrollment.

37.24(3) Guaranteed issue time periods.

a. In the case of an individual described in paragraph 37.24(2)*"a,"* the guaranteed issue period begins on the date the individual receives a notice of termination or cessation of some or all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such a termination or cessation) and ends 63 days after the date of the applicable notice.

b. In the case of an individual described in paragraph 37.24(2)*"b," "c," "e"* or *"f"* whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

c. In the case of an individual described in subparagraph 37.24(2)*"d"*(1), the guaranteed issue period begins on the earlier of (1) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice, if any, and (2) the date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated.

d. In the case of an individual described in paragraph 37.24(2)*"b,"* subparagraph 37.24(2)*"d"*(2), subparagraph 37.24(2)*"e"*(2), paragraph 37.24(2)*"e"* or paragraph 37.24(2)*"f"* who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date.

e. In the case of an individual described in subrule 37.24(2) but not described in the preceding paragraphs 37.24(3)*"a"* to *"d,"* the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

37.24(4) Extended Medigap access for interrupted trial periods.

a. In the case of an individual described in paragraph 37.24(2)*"e"* (or deemed to be so described pursuant to paragraph 37.24(4)*"a"*) whose enrollment with an organization or provider described in paragraph 37.24(2)*"e"* is involuntarily terminated within the first 12 months of enrollment and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment as described in paragraph 37.24(2)*"e."*

b. In the case of an individual described in paragraph 37.24(2)*"f"* (or deemed to be so described pursuant to paragraph 37.24(4)*"b"*) whose enrollment with a plan or in a program described in paragraph 37.24(2)*"f"* is involuntarily terminated within the first 12 months of enrollment and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment as described in paragraph 37.24(2)*"f."*

c. For purposes of paragraphs 37.24(2)*"e"* and *"f,"* no enrollment of an individual with an organization or provider described in paragraph 37.24(2)*"e,"* or with a plan or in a program described in paragraph 37.24(2)*"f,"* may be deemed to be an initial enrollment under paragraph 37.24(4)*"c"* after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

37.24(5) Products to which eligible persons are entitled. The Medicare supplement policy to which eligible persons are entitled under:

a. Subrule 37.24(2), paragraphs *"a," "b," "c,"* and *"d,"* is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F offered by any issuer.

b. Paragraph 37.24(2)*"e"* is the same Medicare supplement policy in which the individual was most recently previously enrolled if available from the same issuer, or, if not so available, a policy described in paragraph 37.24(5)*"a."*

c. Paragraph 37.24(2)*"f"* shall include any Medicare supplement policy offered by any issuer.

37.24(6) Notification of provisions.

a. At the time of an event described in subrule 37.24(2) because of which an individual loses coverage or benefits due to the termination or change of a contract or agreement, policy, or plan, the organization that terminates or changes the contract or agreement, the issuer terminating or changing the policy, or the administrator of the plan being terminated or changed, respectively, shall notify the individual of the individual's rights under this rule and of the obligations of issuers of Medicare supplement policies under subrule 37.24(1). Such notice shall be communicated contemporaneously with the notification of termination.

b. At the time of an event described in subrule 37.24(2) because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the individual's rights under this rule and of the obligations of issuers of Medicare supplement policies under subrule 37.24(1). Such notice shall be communicated within ten working days of the issuer receiving notification of the disenrollment.

These rules are intended to implement Iowa Code chapter 514D.

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CHAPTER 76
EXTERNAL REVIEW

191—76.1(514J) Purpose. This chapter is intended to implement Iowa Code chapter 514J to provide a uniform process for enrollees of carriers and organized delivery systems providing health insurance coverage to request an external review of a coverage decision based upon medical necessity. Carriers defined in Iowa Code section 514J.2(1) and organized delivery systems as defined in Iowa Code section 514J.2(6) are subject to these rules.

191—76.2(514J) Applicable law. The rules contained in this chapter shall apply to any sickness or accident plan and any plan of health insurance, health care benefits or health care services delivered or issued for delivery in this state by an insurance company, a health maintenance organization, or a nonprofit health service corporation, and any plan established pursuant to Iowa Code chapter 509A.

191—76.3(514J) Notice of coverage decision and content. The notice required under Iowa Code chapter 514J shall contain the following information:

1. The enrollee was covered by the carrier at the time the service or treatment was proposed;
2. The enrollee has been denied coverage based on a determination by the carrier that the proposed service or treatment does not meet the definition of medical necessity;
3. The enrollee or the enrollee's treating health care provider acting on behalf of the enrollee has exhausted all internal appeal mechanisms provided under the carrier's evidence of coverage; and
4. Information on how the enrollee or the enrollee's treating health care provider can request an external review. The information provided shall specify the following:

- The enrollee or the enrollee's treating health care provider must send the request for an external review within 60 days of receipt of the coverage decision from the carrier;
- The request shall be made to the Division of Insurance, 330 Maple Street, Des Moines, Iowa 50319;
- A copy of the carrier's coverage decision shall accompany the written request for an external review;
- A $25 filing fee is required unless the enrollee is requesting that the fee be waived. The check should be made payable to the Insurance Division. If a waiver is requested, the request shall include an explanation of why the enrollee is requesting that the fee be waived.

191—76.4(514J) External review request.

76.4(1) The enrollee shall send a copy of the carrier's or organized delivery system's written notice containing the coverage decision with the enrollee's request for an external review to the insurance commissioner within 60 days of the receipt of the coverage decision. The notice shall be sent to the commissioner at the Insurance Division, 330 Maple Street, Des Moines, Iowa 50319.

76.4(2) A $25 filing fee shall be enclosed with the external review request. The commissioner may waive the fee for good cause.

191—76.5(514J) Certification process.

76.5(1) The commissioner shall fax the certification decision to the carrier or organized delivery system and the enrollee or the enrollee's treating health care provider acting on behalf of the enrollee within the two-day period specified in Iowa Code section 514J.5(1).

76.5(2) The commissioner has two business days to rule on a carrier's or organized delivery system's contest of the commissioner's certification decision. The commissioner shall provide a written notice of the determination by fax within the two-day period to the carrier or organized delivery system and the enrollee or the enrollee's treating health care provider acting on behalf of the enrollee.

191—76.6(514J) Expedited review.

76.6(1) The enrollee's treating health care provider shall directly contact the carrier or organized delivery system for an expedited review if the enrollee's treating health care provider states that delay would pose an imminent or serious threat to the enrollee.

76.6(2) The enrollee's treating health care provider and the carrier or organized delivery system shall select within 72 hours an independent review entity to conduct the external review. In the event that the enrollee's treating health care provider and the carrier or organized delivery system cannot reach an agreement upon the selection of an independent review entity, the enrollee's treating health care provider shall notify the commissioner who shall select an independent review entity.

76.6(3) The carrier or organized delivery system and the enrollee's treating health care provider shall provide any additional medical information to the review entity.

76.6(4) The enrollee's treating health care provider shall notify the commissioner of the expedited review request following the agreement in subrule 76.6(2).

76.6(5) In the event the carrier or organized delivery system does not find that a delay would pose an imminent or serious threat to the enrollee, the enrollee's treating health care provider may ask the commissioner to immediately review the request for certification as an expedited review.

76.6(6) A review by the commissioner under subrule 76.6(5) shall stay the 72-hour expedited review time period.

191—76.7(514J) Decision notification. The independent review entity shall immediately notify the carrier or organized delivery system, enrollee or enrollee's treating health care provider, and insurance division of the external appeal decision. The initial notification shall be delivered by telephone or fax transmission, and a hard copy of the notice may be delivered by regular mail.

191—76.8(514J) Carrier information.

76.8(1) Each carrier or organized delivery system shall provide to the commissioner the name or title, telephone and fax numbers and E-mail address of an individual who shall be the carrier's or organized delivery system's contact person for external review procedures. Any changes in personnel or communication numbers shall be immediately sent to the commissioner.

76.8(2) Each carrier or organized delivery system shall provide to the commissioner a detailed description of the process the carrier or organized delivery system has in place to ensure compliance with the requirements found in this chapter and in Iowa Code chapter 514J. The description shall include:

a. An explanation of how the carrier or organized delivery system determines when a person has qualified for external review and should receive a notice from the carrier or organized delivery system, and

b. A copy of the notice sent to persons who fall within the scope of the law.

Information required by this subrule shall be filed by March 1, 2002, and thereafter biennially on March 1.

191—76.9(514J) Certification of independent review entity.

76.9(1) The following minimum standards are required for certification as an independent review entity:

a. The individual must hold a current unrestricted license to practice a health care profession in the United States.

b. A health care professional who is a medical physician shall also hold a certification by a recognized American medical specialty board.

c. A health care professional who is not a medical physician shall also hold a current certification by the professional's respective licensing or specialty board if applicable.

d. The applicant must attest that reviewers have no history of disciplinary actions or sanctions including, but not limited to, the loss of staff privileges or any participation restriction taken or pending by any hospital or state or federal government regulatory agency for wrongdoing by the health care professional.

e. The applicant shall provide a description of the qualifications of the reviewers retained to conduct external reviews of coverage decisions including the reviewers' current and past employment histories and practice affiliations.

f. The applicant shall provide a description of the procedures employed to ensure that reviewers conducting external reviews are appropriately licensed, registered or certified; trained in the principles, procedures and standards of the independent review entity; and knowledgeable about the health care service which is the subject of the external review.

g. The applicant shall provide a description of the methods of recruiting and selecting impartial reviewers and matching such reviewers to specific cases.

h. The applicant shall provide the number of reviewers retained by the independent review entity and a description of the areas of expertise available from such reviewers and the types of cases such reviewers are qualified to review.

i. The applicant shall provide a description of the policies and procedures employed to protect confidentiality of individual medical and treatment records in accordance with applicable state and federal law.

j. The applicant shall provide a description of the quality assurance program established by the independent review entity.

k. The applicant shall provide the names of all corporations and organizations owned or controlled by the independent review entity or which own or control the applicant, and the nature and extent of any such ownership or control.

l. The applicant shall provide the names and résumés of all directors, officers, and executives of the independent review entity.

m. The applicant shall provide a description of the fees to be charged by the review entity for external reviews.

n. The applicant shall provide the name of the medical director or health professional director responsible for the supervision and oversight of the independent review procedure.

76.9(2) The independent review entity shall develop written policies and procedures governing all aspects of the external review process including, at a minimum, the following:

a. Procedures to ensure that external reviews are conducted within the time frames specified in this chapter and Iowa Code chapter 514J and that any required notices are provided in a timely manner.

b. Procedures to ensure the selection of qualified and impartial reviewers. The reviewers shall be qualified to render impartial determinations relating to the health care service which is the subject of the coverage decision under external review. The reviewers shall be experts in the treatment of the medical condition under review.

c. Procedures to ensure that the enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, is notified in writing of the enrollee's right to object to the independent review entity selected by the carrier or organized delivery system or the person selected as the reviewer by the independent review entity by notifying the commissioner at the Insurance Division, 330 Maple Street, Des Moines, Iowa 50319, within ten days of the mailing of the notice by the independent review entity.

d. Procedures to ensure the confidentiality of medical and health treatment records and review materials.

e. Procedures to ensure adherence to the requirements of this chapter and Iowa Code chapter 514J by any contractor, subcontractor, subvendor, agent or employee affiliated with the certified independent review entity.

76.9(3) The independent review entity shall establish a quality assurance program. The program shall include a written description to be provided to all individuals involved in the program, the organizational arrangements, and the ongoing procedures for the identification, evaluation, resolution and follow-up of potential and actual problems in external reviews performed by the independent review entity and procedures to ensure the maintenance of program standards pursuant to this requirement.

76.9(4) The independent review entity shall establish a toll-free telephone service to receive information relating to external reviews pursuant to this chapter and Iowa Code chapter 514J. The system shall include a procedure to ensure the capability of accepting, recording, or providing instruction to incoming telephone calls during other than normal business hours. The independent review entity shall also establish a facsimile and electronic mail service.

76.9(5) No independent review entity, officer, director, employee, or reviewer employed or engaged to conduct external reviews shall have any material professional affiliation or material financial affiliation with a health plan for which it is conducting a review.

76.9(6) The independent review entity shall provide the commissioner such data, information, and reports as the commissioner determines necessary to evaluate the external review process established under Iowa Code chapter 514J.

76.9(7) Applications shall be submitted in duplicate to the Commissioner of Insurance, 330 Maple Street, Des Moines, Iowa 50319. Applications must be submitted in full to be considered. All applicants will be notified of the certification decision. A list of certified independent review entities shall be maintained at the division of insurance and shall be available through the division's Web site.

These rules are intended to implement Iowa Code chapter 514J as amended by 2001 Iowa Acts, Senate File 500.

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199—1.6(68B) Consent for the sale of goods and services.

1.6(1) *General prohibition.* An official or employee shall not sell, either directly or indirectly, any goods or services to individuals, associations, or corporations subject to the regulatory authority of the board without obtaining written consent as provided in this rule.

1.6(2) *Definitions.*

"Employee" shall mean a full-time employee of the utilities division, the employee's spouse and dependents, a firm in which the employee is a partner, and any corporation in which the employee holds 10 percent or more of the stock either directly or indirectly.

"Employment" means selling of goods or services to another for hire or selling goods or services.

"Official" means an individual appointed to the utilities board, that individual's spouse or dependents, a firm in which the official is a partner, and any corporation in which the official holds 10 percent or more of the stock either directly or indirectly.

"Selling goods or services" may include "employment by" or "employment on behalf of."

1.6(3) *Application for consent.*

a. Written consent shall be obtained at least 30 days in advance of making a sale in the following manner:

(1) For utilities division employees, by written application to the utilities board.

(2) For utilities board members, by written application to the director of the department of management.

b. The written application, filed in the utilities division record center, shall include the following information:

(1) Name of prospective employer;

(2) Term of anticipated employment;

(3) Copy of the employment contract or job description, if available;

(4) Service to be provided, detailing duties or function to be performed;

(5) Description of goods to be sold; and

(6) Direct or indirect relationship to regulated entity.

c. Consent or denial of consent shall be given in writing within 14 days of the written request and shall be retained in the utilities division record center as a public record.

1.6(4) *Conditions of consent for officials.* Consent shall not be given to an official unless all of the following conditions are met:

a. The selling of the good or service does not affect the official's job duties or functions.

b. The selling of the good or service does not include acting as an advocate on behalf of the individual, association, or corporation to the department.

c. The selling of the good or service does not result in the official selling of a good or service to the division on behalf of the individual, association, or corporation.

1.6(5) *Conditions of consent for employees.* Consent shall not be given to an employee unless all of the following conditions are met:

a. The employee's job duties or functions are not related to the division's regulatory authority over the individual, association, or corporation, or the selling of the good or service does not affect the employee's job duties or functions.

b. The selling of the good or service does not include acting as an advocate on behalf of the individual, association, or corporation to the division.

c. The selling of the good or service does not result in the employee selling a good or service to the department on behalf of the individual, association, or corporation.

1.6(6) *Effect of consent.* The consent must be in writing. The consent is valid only for the activities and period described in it and only to the extent that material facts have been disclosed and the actual facts are consistent with those described in the application. Consent can be revoked at any time by notice to the employee or official.

1.6(7) *Participation in utility programs.* Nothing in this rule shall prohibit employees or officials of the utilities division from participating in utility programs on the same terms and conditions offered to other customers.

1.6(8) *Appeal.* An employee may grieve the decision in accordance with 581—Chapter 12 of the Iowa department of personnel rules.

1.6(9) *Notice.* Officials and employees of the utilities division shall be provided a copy of the rule. A copy of the rule shall be provided by the division to each new official and employee upon employment.

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, 350 Maple Street, 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.

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) *Service of documents.*

a. Method of service. Unless otherwise specified, the papers which are required to be served in a proceeding may be served by first-class mail, properly addressed with postage prepaid, or by delivery in person. When a paper is served, the party effecting service shall file with the board proof of service substantially in the form prescribed in board rule 2.2(16) or by admission of service by the party served or his attorney. The proof of service shall be attached to a copy of the paper served. When service is made by the board, the board will attach an affidavit of service, signed by the person serving same, to the original of the paper.

b. Date of service. The date of service shall be the day when the paper served is deposited in the United States mail or is delivered in person.

c. Parties entitled to service. A party or other person filing a notice, motion, or pleading in any proceeding shall serve the notice, motion, or pleading on all other parties. Unless a different requirement is specified in these rules, a party formally filing any such document or any other material 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, 310 Maple Street, Des Moines, Iowa 50319-0069.

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, 350 Maple Street, Des Moines, Iowa 50319.

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.

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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EDUCATIONAL EXAMINERS BOARD[282]

[Prior to 6/15/88, see Professional Teaching Practices Commission[640]]
[Prior to 5/16/90, see Professional Teaching Practices Commission[287]]

CHAPTER 11
COMPLAINTS, INVESTIGATIONS, CONTESTED CASE HEARINGS

CHAPTER 12
CRITERIA OF PROFESSIONAL PRACTICES

CHAPTER 13
CRITERIA OF COMPETENT PERFORMANCE

CHAPTER 14
ISSUANCE OF PRACTITIONER'S LICENSES AND ENDORSEMENTS

RULES IN EFFECT PRIOR TO AUGUST 31, 2001

11.24(10) The presiding officer may render a proposed or final decision imposing appropriate sanctions for violations of this rule including default, a decision against the offending party, censure, or suspension or revocation of the privilege to practice before the department. Violation of ex parte communication prohibitions by department personnel shall be reported to (agency to designate person to whom violations should be reported) for possible sanctions including censure, suspension, dismissal, or other disciplinary action.

282—11.25(17A,272) Recording costs. Upon request, the board shall provide a copy of the whole or any portion of the record at cost. The cost of preparing a copy of the record or of transcribing the hearing record shall be paid by the requesting party.

Parties who request that a hearing be recorded by certified shorthand reporters rather than by electronic means shall bear the cost of that recordation, unless otherwise provided by law.

282—11.26(17A,272) 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 shall weigh the extent to which its 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 of the presiding officer would provide an adequate remedy. Any request for interlocutory review must be filed within 14 days of issuance of the challenged order, but no later than the time for compliance with the order or the date of hearing, whichever is first.

282—11.27(17A,272) Final decision.

11.27(1) When the board presides over the reception of evidence at the hearing, its decision is a final decision.

11.27(2) When the board does not preside at the reception of evidence, the presiding officer shall make a proposed decision. The proposed decision becomes the final decision of the board without further proceedings unless there is an appeal to, or review on motion of, the board within the time provided in rule 11.28(17A,272).

282—11.28(17A,272) Appeals and review.

11.28(1) *Appeal by party.* Any adversely affected party may appeal a proposed decision to the board within 60 days after issuance of the proposed decision.

11.28(2) *Review.* The board may initiate review of a proposed decision on its own motion at any time within 60 days following the issuance of such a decision.

11.28(3) *Notice of appeal.* An appeal of a proposed decision is initiated by filing a timely notice of appeal with the board. The notice of appeal must be signed by the appealing party or a representative of that party and contain a certificate of service. The notice shall specify:

a. The parties initiating the appeal;

b. The proposed decision or order appealed from;

c. The specific findings or conclusions to which exception is taken and any other exceptions to the decision or order;

d. The relief sought;

e. The grounds for relief.

11.28(4) *Requests to present additional evidence.* A party may request the taking of additional evidence only by establishing that the evidence is material, that good cause existed for the failure to present the evidence at the hearing, and that the party has not waived the right to present the evidence. A written request to present additional evidence must be filed with the notice of appeal or, by a non-appealing party, within 14 days of service of the notice of appeal. The board may remand a case to the presiding officer for further hearing or may itself preside at the taking of additional evidence.

11.28(5) *Scheduling.* The board shall issue a schedule for consideration of the appeal.

11.28(6) *Briefs and arguments.* Unless otherwise ordered, within 20 days of the notice of appeal or order for review, each appealing party may file exceptions and briefs. Within 20 days thereafter, any party may file a responsive brief. Briefs shall cite any applicable legal authority and specify relevant portions of the record in that proceeding. Written requests to present oral argument shall be filed with the briefs.

The board may resolve the appeal on the briefs or provide an opportunity for oral argument. The board may shorten or extend the briefing period as appropriate.

282—11.29(17A,272) Applications for rehearing.

11.29(1) *By whom filed.* Any party to a contested case proceeding may file an application for rehearing from a final order.

11.29(2) *Content of application.* The application for rehearing shall state on whose behalf it is filed, the specific grounds for rehearing, and the relief sought. In addition, the application shall state whether the applicant desires reconsideration of all or part of the board decision on the existing record and whether, on the basis of the grounds enumerated in subrule 11.28(4), the applicant requests an opportunity to submit additional evidence.

11.29(3) *Time of filing.* The application shall be filed with the board within 20 days after issuance of the final decision.

11.29(4) *Notice to other parties.* A copy of the application shall be timely mailed by the applicant to all parties of record not joining therein. If the application does not contain a certificate of service, the board shall serve copies on all parties.

11.29(5) *Disposition.* Any application for a rehearing shall be deemed denied unless the board grants the application within 20 days after its filing.

282—11.30(17A,272) Stays of board actions.

11.30(1) *When available.*

a. Any party to a contested case proceeding may petition the board for a stay of an order issued in that proceeding or for other temporary remedies, pending review by the board. The petition shall be filed with the notice of appeal and shall state the reasons justifying a stay or other temporary remedy. The executive director may rule on the stay or authorize the presiding officer to do so.

b. Any party to a contested case proceeding may petition the board for a stay or other temporary remedies pending judicial review of all or part of that proceeding. The petition shall state the reasons justifying a stay or other temporary remedy.

11.30(2) *When granted.* In determining whether to grant a stay, the executive director or presiding officer shall consider the factors listed in 1998 Iowa Acts, chapter 1202, section 23(5c).

11.30(3) *Vacation.* A stay may be vacated by the issuing authority upon application of the board or any other party.

282—11.31(17A,272) No factual dispute contested cases. If the parties agree that no dispute of material fact exists as to a matter that would be a contested case if such a dispute of fact existed, the parties may present all relevant admissible evidence either by stipulation or otherwise as agreed by the parties, without necessity for the production of evidence at an evidentiary hearing. If such agreement is reached, a jointly submitted schedule detailing the method and timetable for submission of the record, briefs and oral argument should be submitted to the presiding officer for approval as soon as practicable. If the parties cannot agree, any party may file and serve a motion for summary judgment pursuant to the rules governing such motions.

282—11.32(17A,272) Emergency adjudicative proceedings.

11.32(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 a written order in compliance with Iowa Code section 17A.18 to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the board by emergency adjudicative order. Before issuing an emergency adjudicative order the board shall consider factors including, but not limited to, the following:

a. Whether there has been a sufficient factual investigation to ensure that the board is proceeding on the basis of reliable information;

b. Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined 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.

11.32(2) *Issuance of order.*

a. An emergency adjudicative order shall contain findings of fact, conclusions of law, and policy reasons to justify the determination of an immediate danger in the 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 utilizing one or more of the following procedures:

(1) Personal delivery;

(2) Certified mail, return receipt requested, to the last address on file with the board;

(3) Certified mail to the last address on file with the board;

(4) First-class mail to the last address on file with the board; or

(5) Fax. Fax may be used as the sole method of delivery if the person required to comply with the order has filed a written request that board orders be sent by fax and has provided a fax number for that purpose.

c. To the degree practicable, the board shall select the procedure for providing written notice that best ensures prompt, reliable delivery.

11.32(3) *Oral notice.* Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the board shall make reasonable immediate efforts to contact by telephone the persons who are required to comply with the order.

11.32(4) *Completion of proceedings.* After the issuance of an emergency adjudicative order, the board shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger.

Issuance of a written emergency adjudicative order shall include notification of the date on which board proceedings are scheduled for completion. After issuance of an emergency adjudicative order, continuance of further board proceedings to a later date will be granted only in compelling circumstances upon application in writing.

282—11.33(272) Methods of discipline. The board has the authority to impose the following disciplinary sanctions:

1. Revoke a practitioner's license, certificate or authorization.

2. Suspend a practitioner's license, certificate or authorization until further order of the board or for a specific period.

3. Prohibit permanently, until further order of the board, or for a specific period, a practitioner from engaging in specified practices, methods, or acts.

4. Require additional education or training.
5. Order a physical or mental evaluation, or order alcohol and drug screening within a time specified by the board.
6. Issue a public letter of reprimand.
7. Order any other resolution appropriate to the circumstances of the case.

282—11.34(272) Reinstatement. Any person whose license, certificate or authorization to practice has been suspended may apply to the board for reinstatement in accordance with the terms and conditions of the order of the suspension.

11.34(1) All proceedings for reinstatement shall be initiated by the respondent, who shall file with the board an application for reinstatement. Such application shall be docketed in the original case in which the license, certificate or authorization was suspended. All proceedings upon the application for reinstatement shall be subject to the same rules of procedure as other cases before the board.

11.34(2) An application for reinstatement shall allege facts which, if established, will be sufficient to enable the board to determine that the basis for the suspension of the respondent's license, certificate or authorization no longer exists and that it will be in the public interest for the license, certificate or authorization to be reinstated. The burden of proof to establish such facts shall be on the respondent.

11.34(3) An order denying or granting reinstatement shall be based upon a decision which incorporates findings of fact and conclusions of law.

282—11.35(272) Application denial and appeal. The executive director is authorized by Iowa Code section 272.7 to grant or deny applications for licensure. If the executive director denies an application for an initial or exchange license, certificate, or authorization, the executive director shall send to the applicant by regular first-class mail written notice identifying the factual and legal basis for denying the application. If the executive director denies an application to renew an existing license, certificate, or authorization, the provisions of rule 11.36(272) shall apply.

11.35(1) *Grounds for license denial.* The executive director may deny an application based on the grounds set forth in Iowa Code sections 272.2(14) and 272.6.

11.35(2) *Conviction of a crime and founded child abuse.* When determining whether a person should be denied licensure based on the conviction of a crime, including a felony, or a founded report of child abuse, the executive director and the board shall consider the following:

a. The nature and seriousness of the crime or founded abuse in relation to the position sought;
b. The time elapsed since the crime or founded abuse was committed;
c. The degree of rehabilitation which has taken place since the crime or founded abuse was committed;
d. The likelihood that the person will commit the same crime or abuse again;
e. The number of criminal convictions or founded abuses committed; and
f. Such additional factors as may in a particular case demonstrate mitigating circumstances or heightened risk to public safety.

11.35(3) *Fraudulent applications.* An application shall be considered fraudulent pursuant to Iowa Code section 272.6(4) if it contains any false representation of a material fact or any omission of a material fact which should have been disclosed at the time of application for licensure or is submitted with a false or forged diploma, certificate, affidavit, identification, or other document material to the applicant's qualification for licensure or material to any of the grounds for denial set forth in Iowa Code sections 272.2(14) and 272.6.

11.35(4) *Appeal procedure.*

a. An applicant who is aggrieved by the denial of an application for licensure and who desires to challenge the decision of the executive director must appeal the decision and request a hearing before the board within 30 calendar days of the date the notice of license denial is mailed. An appeal and request for hearing must be in writing and is deemed made on the date of the United States Postal Service nonmetered postmark or the date of personal service to the board office. The request for hearing shall specify the factual or legal errors the applicant contends were made by the executive director, must identify any factual disputes upon which the applicant desires an evidentiary hearing, and may provide additional written information or documents in support of licensure. If a request for hearing is timely made, the executive director shall promptly issue a notice of contested case hearing on the grounds asserted by the applicant.

b. The board, in its discretion, may act as presiding officer at the contested case hearing, may hold the hearing before a panel of three board members, or may request that an administrative law judge act as presiding officer. The applicant may request that an administrative law judge act as presiding officer and render a proposed decision pursuant to rule 11.8(17A,272). A proposed decision by a panel of board members or an administrative law judge is subject to appeal or review by the board pursuant to rule 11.28(17A,272).

c. Hearings concerning licensure denial shall be conducted according to the contested case procedural rules in this chapter. Evidence supporting the denial of the license may be presented by an assistant attorney general. While each party shall have the burden of establishing the affirmative of matters asserted, the applicant shall have the ultimate burden of persuasion as to the applicant's qualification for licensure.

d. On appeal, the board may grant or deny the application for licensure. If the application for licensure is denied, the board shall state the reason or reasons for the denial and may state conditions under which the application could be granted, if applicable.

11.35(5) *Judicial review.* Judicial review of a final order of the board denying licensure may be sought in accordance with the provisions of Iowa Code section 17A.19 which are applicable to judicial review of an agency's final decision in a contested case. In order to exhaust administrative remedies, an applicant aggrieved by the executive director's denial of an application for licensure must timely appeal the adverse decision to the board.

282—11.36(272) Denial of renewal application. If the executive director denies an application to renew a license, certificate or authorization, a notice of hearing shall be issued to commence a contested case proceeding. The executive director may deny a renewal application on the same grounds as those that apply to an application for initial or exchange licensure described in subrules 11.35(1) to 11.35(3).

11.36(1) *Hearing procedure.* Hearings on denial of an application to renew a license shall be conducted according to the contested case procedural rules in this chapter. Evidence supporting the denial of the license may be presented by an assistant attorney general. The provisions of subrules 11.35(4) and 11.35(5) shall apply.

11.36(2) *Judicial review.* Judicial review of a final order of the board denying renewal of licensure may be sought in accordance with the provisions of Iowa Code section 17A.19 which are applicable to judicial review of an agency's final decision in a contested case.

11.36(3) *Impact of denial of renewal application.* Pursuant to Iowa Code section 17A.18(2), if the licensee has made timely and sufficient application for renewal, an existing license shall not expire until the last day for seeking judicial review of the board's final order denying the application or a later date fixed by order of the board or reviewing court.

11.36(4) *Timeliness of renewal application.* Within the meaning of Iowa Code section 17A.18(2), a timely and sufficient renewal application shall be:

a. Received by the board on or before the date the license is set to expire or lapse;

b. Signed by the licensee if submitted in paper form or certified as accurate if submitted electronically;

c. Fully completed; and

d. Accompanied by the proper fee. The fee shall be deemed improper if the amount is incorrect, the fee was not included with the application, or the licensee's check is unsigned or returned for insufficient funds.

These rules are intended to implement Iowa Code chapters 17A and 272.

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◊Two ARCs

CHAPTER 12
CRITERIA OF PROFESSIONAL PRACTICES

[Prior to 6/15/88, see Professional Teaching Practices Commission[640] Ch 3]
[Prior to 5/16/90, see Professional Teaching Practices Commission[287] Ch 3]

282—12.1(272) Contractual and other legal obligations.

12.1(1) *Statutory provisions.*

a. The board recognizes the need for all members of the profession to be cognizant of the statutes of the state of Iowa which deal with contractual and other legal obligations. A violation of any of the school laws of Iowa constitutes a violation of the criteria of the board of educational examiners.

b. The board recognizes its responsibility to investigate cases which involve the habitual failure of a practitioner to fulfill contractual obligations under Iowa Code section 279.13.

12.1(2) *Written contracts.* The board recognizes the need for a common basis upon which teachers and boards of education may agree. The effectiveness of a written contract will be dependent upon mutual confidence and good faith in which both parties enter into and agree. Boards of education have final authority and responsibility to enter into written contractual agreements.

282—12.2(272) Conviction of crimes, sexual and other immoral conduct with or toward students and alcohol or drug abuse.

12.2(1) It is hereby deemed unprofessional and in violation of the criteria of this board for a member of the teaching profession to be guilty of any of the following acts or offenses:

a. Fraud in the procurement or renewal of a practitioner's license as defined in Iowa Code chapter 272.

b. The commission of or conviction for a public offense as defined by the Criminal Code of Iowa, provided that the offense is relevant to and affects teaching or administrative performance.

c. Sexual involvement with a student. Sexual involvement includes the following acts, whether consensual or nonconsensual: fondling or touching the inner thigh, groin, buttocks, anus, or breasts of a student; permitting or causing to fondle or touch the practitioner's inner thigh, groin, buttocks, anus, or breasts; or the commission of any sex act as defined in Iowa Code section 702.17.

d. Chronic abuse of or addiction to alcohol or other drugs, where such abuse or addiction affects performance of educational duties. Where drug addiction has been caused by the use of drugs under the directions of a physician, the board shall allow a reasonable period of time for treatment before taking any action affecting the practitioner's license.

e. Physical or sexual abuse of a child as evidenced by a founded abuse report against the person.

12.2(2) In determining whether a person should be denied a license or whether a licensee should be disciplined based upon a criminal conviction or founded report of physical or sexual abuse of a child, the board shall consider:

a. The nature and seriousness of the founded abuse or crime in relation to the position sought;

b. The time elapsed since the founded abuse or crime was committed;

c. The degree of rehabilitation which has taken place since the incidence of founded abuse or the commission of the crime;

d. The likelihood that the person will commit the same abuse or crime again; and

e. The number of founded abuses committed or criminal convictions by the person involved.

282—12.3(272) Ethical practice toward other members of the profession, parents, students and the community.

12.3(1) *Principle I—commitment to the student.* The educator measures success by the progress of each student toward realization of potential as a worthy and effective citizen. The educator therefore works to stimulate the spirit of inquiry, the acquisition of knowledge and understanding, and the thoughtful formulation of worthy goals. In fulfilling obligations to the student, the educator:

a. Shall not without just cause restrain the student from independent action in a pursuit of learning, and shall not without just cause deny the student access to varying points of view.

b. Shall not deliberately suppress or distort subject matter for which the educator bears responsibility.

c. Shall make reasonable effort to protect the student from conditions harmful to learning or to health and safety.

d. Shall conduct professional business in such a way that the educator does not expose the student to unnecessary embarrassment or disparagement.

e. Shall not on the ground of race, color, creed, age, sex, physical or mental handicap, marital status, or national origin exclude any student from participation in or deny the student benefits under any program, nor grant any discriminatory consideration or advantage.

f. Shall not use professional relationships with students for private advantage.

g. Shall keep in confidence information that has been obtained in the course of professional service, unless disclosure serves professional purposes or is required by law.

h. Shall not tutor for remuneration students assigned to the educator's classes, unless no other qualified teacher is reasonably available.

12.3(2) *Principle II—commitment to the public.* The educator believes that patriotism in its highest form requires dedication to the principles of our democratic heritage. The educator shares with all other citizens the responsibility for the development of sound public policy and assumes full political and citizenship responsibilities. The educator bears particular responsibility for the development of policy relating to the extension of educational opportunities for all and for interpreting educational programs and policies to the public. In fulfilling an obligation to the public, the educator:

a. Shall not misrepresent an institution or organization with which the educator is affiliated, and shall take adequate precautions to distinguish between personal and institutional or organizational views.

b. Shall not knowingly distort or misrepresent the facts concerning educational matters in direct and indirect public expressions.

c. Shall not interfere with a colleague's exercise of political and citizenship rights and responsibilities.

d. Shall not use institutional privileges for monetary private gain or to promote political candidates or partisan political activities.

e. Shall accept no gratuities, gifts, or favors that might impair or appear to impair professional judgment, nor offer any favor, service, or thing of value to obtain special advantage.

12.3(3) *Principle III—commitment to the profession.* The educator believes that the quality of the services of the education profession directly influences the nation and its citizens. The educator therefore exerts every effort to raise professional standards, to improve service, to promote a climate in which the exercise of professional judgment is encouraged, and to achieve conditions which attract persons worthy of the trust to careers in education. In fulfilling an obligation to the profession, the educator:

a. Shall not discriminate on the ground of race, sex, age, physical handicap, marital status, color, creed or national origin for membership in the profession, nor interfere with the participation or nonparticipation of colleagues in the affairs of their professional association.

b. Shall accord just and equitable treatment to all members of the profession in the exercise of their professional rights and responsibilities.

c. Shall not use coercive means or promise special treatment in order to influence professional decisions of colleagues.

d. Shall withhold and safeguard information acquired about colleagues in the course of employment, unless disclosure serves professional purposes.

e. Shall not refuse to participate in a professional inquiry when requested by the commission board.

f. Shall provide upon the request of the aggrieved party a written statement of specific reason for recommendations that lead to the denial of increments, significant changes in employment or termination of employment.

g. Shall not misrepresent professional qualifications.

h. Shall not knowingly distort evaluations of colleagues.

12.3(4) *Principle IV—commitment to professional employment practices.* The educator regards the employment agreement as a pledge to be executed both in spirit and in fact in a manner consistent with the highest ideals of professional service. The educator believes that sound professional personnel relationships with governing boards are built upon personal integrity, dignity, and mutual respect. The administrator discourages the practice of the profession by unqualified persons. In fulfilling the obligation to professional employment practices, the educator:

a. Shall apply for, accept, offer, or assign a position or responsibility on the basis of professional preparation and legal qualifications.

b. Should recognize salary schedules and the salary clause of an individual teacher's contract as a binding document on both parties. The educator should not in any way violate the terms of the contract.

c. Shall not knowingly withhold information regarding a position from an applicant or misrepresent an assignment or conditions of employment.

d. Shall give prompt notice to the employing agency of any change in availability of service, and the employing agent shall give prompt notice of change in availability or nature of a position.

e. Shall adhere to the terms of a contract or appointment, unless these terms have been legally terminated, falsely represented, or substantially altered by unilateral action of the employing agency.

f. Shall not delegate assigned tasks to unqualified personnel.

g. Shall use time or funds granted for the purpose for which they were intended.

12.3(5) *Principle V—commitment of board members and staff.* The board members and staff will be independent and impartial and not use the public office for private gain. In fulfilling their obligation the board employees will not:

a. Receive any remuneration for services, other than that payable by law.

b. Solicit, accept, or agree to accept any gifts, loans, gratuities, discounts, favors, hospitalities or services from anyone with vested interests in board matters.

c. Disclose confidential information garnered from official duties.

d. Solicit, accept or agree to accept compensation contingent upon board actions.

e. Hold positions, perform duties, or engage in activities not compatible with official capacity.

These rules are intended to implement Iowa Code chapter 272.

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282—14.104(272) Applicants from foreign institutions. An applicant for initial licensure whose preparation was completed in a foreign institution will be required to have all records translated into English and then file these records with the board of educational examiners for a determination of eligibility for licensure.

282—14.105(272) Issue date on original license. A license is valid only from and after the date of issuance.

282—14.106(272) Adding endorsements to licenses. After the issuance of a teaching, administrative, or school service personnel license, an individual may add other endorsements to that license upon proper application, provided current requirements for that endorsement, as listed in 282—14.140(272) and 282—14.141(272), have been met. An updated license with expiration date unchanged from the original or renewed license will be prepared.

In addition to the requirements listed in 282—14.140(272) and 282—14.141(272), applicants for endorsements shall have completed a methods class appropriate for teaching the general subject area of the endorsement added.

Practitioners who are adding a secondary teaching endorsement and have not student taught on the secondary level shall complete a teaching practicum appropriate for teaching at the level of the new endorsement.

Practitioners holding the K-6 endorsement in the content area of the 7-12 endorsement being added may satisfy the requirement for a teaching practicum by completing all required coursework and presenting verification of competence. This verification of competence shall be signed by a licensed evaluator who has observed and formally evaluated the performance of the applicant at the secondary level.

14.106(1) To add an endorsement, the applicant must follow one of these options:

Option 1. Identify with a recognized Iowa teacher preparing institution, meet that institution's current requirements for the endorsement desired, and receive that institution's recommendation.

Option 2. Identify with a recognized Iowa teacher education institution and receive a statement that the applicant has completed the equivalent of the institution's approved program for the endorsement sought.

Option 3. Identify with a recognized teacher education institution and receive a statement that based on the institution's evaluation of the individual's preparation the applicant has completed all of the Iowa requirements for the endorsement sought.

14.106(2) Appeal. If an applicant cannot obtain a recommendation for an endorsement from an institution, and if the applicant can document that all of the Iowa requirements have been met, the applicant may apply for the endorsement by filing transcripts and supporting documentation for review. The application must be accompanied by a letter or rejection from an institution that offers the endorsement. Upon receipt of all materials, the staff of the board of educational examiners will review documents to determine if all Iowa requirements have been met.

282—14.107(272) Correcting licenses. If, at the time of the original issuance or renewal of a license, a person does not receive an endorsement for which the individual is eligible, a corrected license shall be issued. Also, a corrected license shall be issued if a person receives an endorsement for which the person is not eligible.

282—14.108(272) Duplicate licenses. Upon application and payment of the fee set out in subrule 14.121(3), duplicate licenses shall be issued.

282—14.109(272) Fraud in procurement or renewal of licenses. Fraud in procurement or renewal of a license or falsifying records for licensure purposes will constitute grounds for filing a complaint with the board of educational examiners.

282—14.110(272) Licenses. The following licenses will be issued effective August 31, 2001:

1. Initial.
2. Standard.
3. Master educator.
4. Professional administrator.
5. Conditional.
6. Substitute.
7. Area education agency administrator.
8. Alternative preparation.

282—14.111(272) Requirements for an initial license. An initial license valid for two years may be issued to an applicant who:

1. Has a baccalaureate degree from a regionally accredited institution.
2. Has completed a state-approved teacher education program which meets the requirements of the professional education core.
3. Has completed an approved human relations component.
4. Has completed the exceptional learner component.
5. Has completed the requirements for one of the basic teaching endorsements, the special education teaching endorsements, or the secondary level occupational endorsements.
6. Meets the recency requirement of 14.115"3."

Renewal requirements for this license are set out in 282—Chapter 17.

282—14.112(272) Requirements for a standard license. A standard license valid for five years may be issued to an applicant who:

1. Completes items "1" to "5" listed under 282—14.111(272).
2. Shows evidence of successful completion of a state-approved induction program or an approved alternative option or two years' successful teaching experience based on a local evaluation process.
3. Meets the recency requirement of 14.115"3."

Renewal requirements for this license are set out in 282—Chapter 17.

282—14.113(272) Requirements for a master educator's license. A master educator's license valid for five years may be issued to an applicant who:

1. Is the holder of or eligible for a standard license.
2. Verifies five years of successful teaching experience.
3. Completes one of the following options:

- Master's degree in a recognized endorsement area, or
- Master's degree in curriculum, effective teaching, or a similar degree program which has a focus on school curriculum or instruction.

Renewal requirements for this license are set out in 282—Chapter 17.

A person shall not be issued a temporary or emergency license for more than one year. An area education agency shall neither employ unlicensed administrators nor employ temporary or emergency licensed administrators for more than two consecutive years.

These rules are intended to implement Iowa Code chapter 272.

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◊Two or more ARCs
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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.

b. The administrator of the division of economic assistance is responsible for the development and direction of financial assistance programs, including the family investment program, the food stamp program, emergency assistance, PROMISE JOBS, entrepreneurial training, refugee cash assistance, the family development and self-sufficiency demonstration program, systematic alien verification for entitlements, diversion programs, individual development accounts, and the food stamp employment and training program.

c. The administrator of the division of medical services is responsible for the development and direction of medical service programs, including Medicaid, state supplementary assistance, refugee medical assistance, the child health insurance program (HAWK-I), and interim assistance reimbursement.

d. The administrator of the division of mental health and developmental disabilities is responsible for the development and direction of supports and services as well as the financing of such services for persons with mental illness, mental retardation, and developmental disabilities. Additionally, the administrator is responsible for setting program policy for the following institutions and programs:

(1) Cherokee Mental Health Institute.

(2) Clarinda Mental Health Institute, located on the grounds of the Clarinda Treatment Complex Institute Campus.

(3) Independence Mental Health Institute.

(4) Mount Pleasant Mental Health Institute, located on the grounds of the Mount Pleasant Treatment Center Complex.

(5) Glenwood State Hospital-School.

(6) Woodward State Hospital-School.

(7) The Civil Commitment of Sexual Offenders Unit at Oakdale.

e. The administrator of the division of policy and rule integration is responsible for providing leadership and direction agencywide for the integration of policy development and the consistency of rules, including ensuring that program policies are consistent with state and federal law and are designed to achieve programmatic goals and results; monitoring state and federal programmatic policy and financial changes; and identifying policy and rule changes to ensure alignment with program and administrative divisions to facilitate alignment with the department's mission.

1.3(3) *Deputy director for operations.* The deputy director for operations manages the delivery of the financial, medical and social services programs for eligible Iowans. The administrators of the division of child support, case management, and refugee services and the office of field support and the administrators of the five departmental regions report directly to the deputy director for operations. Additionally, the deputy director is responsible for policy implementation and day-to-day operations at the following institutions: the state training school in Eldora; the Iowa juvenile home in Toledo; Cherokee Mental Health Institute; Clarinda Mental Health Institute, located on the grounds of the Clarinda Treatment Complex Institute Campus; Independence Mental Health Institute; Mount Pleasant Mental Health Institute, located on the grounds of the Mount Pleasant Treatment Center Complex; Glenwood State Hospital-School; Woodward State Hospital-School; and the Civil Commitment of Sexual Offenders Unit at Oakdale.

a. The administrator of the division of child support, case management, and refugee services is responsible for primary support services to all line elements of the department in the areas of child support and foster care collections and refugee services, and has responsibility for the department's Title XIX case management policy and budget.

b. The chief of the office of field support is responsible for the day-to-day contact with the regional offices on administrative and program operation issues and addressing client or constituent concerns.

1.3(4) *Office of communications.* The office of communications addresses the different facets of the department's internal and external communication needs. The office of communications is responsible for providing public information to clients, constituency groups, and the media, while also facilitating internal communications within the department.

a. The legislative liaison provides federal and state liaison services, maintains legislative relations, and reviews client and constituent concerns.

b. The internal communications consultant addresses the different facets of the department's internal communication needs.

c. The public information officer is responsible for the department's external communication to the media and other outside stakeholders.

441—1.4(17A) Field operations structure.

1.4(1) *Delivery system.* The department's community service delivery system is based on service areas with offices in each county that are strategically located for purposes of client accessibility. Each service area is headed by a service area manager who is responsible for the following within the service area: effective management of the delivery of social services within the area, management of the department offices, directing all personnel, implementation of departmental policies and procedures, support for the development of social service resources within the community, and resolution of service delivery complaints. The services delivered in a service area include income maintenance and social service programs, child protection and other specialized services.

1.4(2) *Local offices.* There shall be at least one local office in each county. These local offices may be full-time or less than full-time. Full-time offices will provide income maintenance and social service program delivery and will serve as a base for the less than full-time office staff. Additional services offered in local offices may include child protection and other specialized services. Less than full-time offices will be operated on a reduced number of days per week based on county need and will provide income maintenance and social services.

This rule is intended to implement Iowa Code section 17A.3(1)*"a."*

441—1.5 Rescinded, effective October 1, 1987.

441—1.6(17A) Mental health and developmental disabilities commission. The administrator of the division of mental health and developmental disabilities has, by statute, the advice and counsel of the mental health and mental retardation commission. This 15-member commission is appointed by the governor with confirmation by two-thirds of the members of the senate. The commission's powers and duties are policymaking and advisory with respect to mental health and mental retardation, services, and programs administered by the division of mental health and developmental disabilities.

441—1.10(17A) HAWK-I board. The director of the department has, by statute, the advice and counsel of the HAWK-I board on the healthy and well children in Iowa program. This seven-member board consists of the commissioner of insurance or the commissioner's designee, the director of the department of education or the director's designee, the director of the department of public health or the director's designee, and four public members appointed by the governor, subject to confirmation by two-thirds of the members of the senate. The board shall also include two members of the senate and two members of the house of representatives, serving as ex officio members.

1.10(1) *Organization.*

a. The members of the board shall annually elect from the board's voting membership a chairperson of the board.

b. Members appointed by the governor and the legislative members shall serve two-year terms.

1.10(2) *Duties and powers of the board.* The board's powers and duties are to make policy and to provide direction for the administration of all aspects of the healthy and well kids in Iowa program which is administered by the division of medical services. In carrying out these duties, the board shall do all of the following:

a. Adopt rules of the department.

b. Develop criteria for and approve all contracts.

c. Establish a clinical advisory committee.

d. Establish an advisory committee on children with special health care needs.

e. Conduct studies and evaluations and provide reports as directed by legislation.

f. Define regions of the state for which plans are offered.

g. Solicit input from the public about the program.

h. Improve interaction between the program and other public and private programs which provide services to eligible children.

i. Receive and accept grants, loans, or other advances of funds from any person and may receive and accept from any source contributions of money, property, labor, or any other thing of value, to be held, used, and applied for the purpose of the program.

1.10(3) *Board action.*

a. A quorum shall consist of two-thirds of the membership appointed and qualified to vote.

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

1.10(4) *Board minutes.*

a. Copies of administrative rules and other materials considered are made part of the minutes by reference.

b. Copies of the minutes are kept on file in the office of the administrator of the division of medical services.

1.10(5) *Board meetings.*

a. The board shall meet at regular intervals at least ten times each year and may hold special meetings at the call of the chairperson or at the request of a majority of the voting members.

b. Any person wishing to make a presentation at a board meeting shall notify the Administrator, Division of Medical Services, Department of Human Services, Hoover State Office Building, Des Moines, Iowa 50309-0114, telephone (515)281-8794, at least 15 days prior to the board meeting.

1.10(6) *Robert's Rules of Order.* In cases not covered by these rules, Robert's Rules of Order shall govern.

This rule is intended to implement Iowa Code paragraph 17A.3(1)*"a"* and 1998 Iowa Acts, chapter 1196, section 6.

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3.5(2) *Oral proceedings.* The department may, at any time, schedule an oral proceeding on a proposed rule. The department shall schedule an oral proceeding on a proposed rule if, within 20 days after the published Notice of Intended Action, a written request for an opportunity to make oral presentations is submitted to the department by the administrative rules review committee, a governmental subdivision, a state agency, an association having not less than 25 members, or at least 25 persons. That request must also contain the following additional information:

1. A request by one or more individual persons must be signed by each of them and include the address and telephone number of each of them.

2. A request by an association must be signed by an officer or designee of the association and must contain a statement that the association has at least 25 members and the address and telephone number of the person signing that request.

3. A request by a state agency or governmental subdivision must be signed by an official having authority to act on behalf of the entity and must contain the address and telephone number of the person signing that request.

The department may waive technical compliance with these procedures.

Oral proceedings scheduled by the department regarding rules directly affecting indigent clients shall be held in each of the service areas defined in rule 441—1.4(17A).

In the case of rules not directly affecting indigent clients, the department shall determine for each rule for which oral proceedings are scheduled whether it will be necessary to hold presentations in all eight locations. Anyone may object to the department's decision prior to the date of the proceedings by writing the same addressee specified in the Notice of Intended Action for receiving written data, views, or arguments. The department shall review the adequacy of the number of locations in light of the comments received.

3.5(3) *Conduct of oral proceedings.*

a. Applicability. This subrule applies only to those oral rule-making proceedings in which an opportunity to make oral presentations is authorized or required by Iowa Code section 17A.4(1)*"b"* as amended by 1998 Iowa Acts, chapter 1202, section 8, or subrule 3.5(2).

b. Scheduling and notice. An oral proceeding on a proposed rule may be held in one or more locations and shall not be held earlier than 20 days after notice of its location and time is published in the Iowa Administrative Bulletin. That notice shall also identify the proposed rule by ARC number and citation to the Iowa Administrative Bulletin.

c. Presiding officer. An employee of the department shall preside at the oral proceeding on the proposed rules and shall present a prepared statement on the substance of the rules. The presiding officer shall transcribe the proceeding or prepare a written summary of the presentations made.

d. Conduct of proceeding. At an oral proceeding on a proposed rule, persons may make oral statements and make documentary and physical submissions, which may include data, views, comments or arguments concerning the proposed rule. Persons wishing to make oral presentations at the proceeding are encouraged to notify the department at least one business day prior to the proceeding and indicate the general subject of their presentations. At the proceeding, those who participate shall indicate their names and addresses, identify any persons or organizations they represent, and provide any other information relating to their participation deemed appropriate by the presiding officer. Oral proceedings shall be open to the public and shall be recorded by stenographic or electronic means.

(1) At the beginning of the oral proceeding, the presiding officer shall give a brief synopsis of the proposed rule, a statement of the statutory authority for the proposed rule, and the reasons for the department decision to propose the rule. The presiding officer may place time limitations on individual oral presentations when necessary to ensure the orderly and expeditious conduct of the oral proceeding. To encourage joint oral presentations and to avoid repetition, additional time may be provided for persons whose presentations represent the views of other individuals as well as their own views.

(2) Whenever possible, persons making oral presentations should submit their testimony in writing.

(3) To facilitate the exchange of information, the presiding officer may, where time permits, open the floor to questions or general discussion.

(4) The presiding officer shall have the authority to take any reasonable action necessary for the orderly conduct of the meeting.

(5) Physical and documentary submissions presented by participants in the oral proceeding shall be submitted to the presiding officer. These submissions become the property of the department.

(6) The oral proceeding may be continued by the presiding officer to a later time without notice other than by announcement at the hearing.

(7) Participants in an oral proceeding shall not be required to take an oath or to submit to cross-examination. However, the presiding officer in an oral proceeding may question participants and permit the questioning of participants by other participants about any matter relating to that rule-making proceeding, including any prior written submissions made by those participants in that proceeding; but no participant shall be required to answer any question.

(8) The presiding officer in an oral proceeding may permit rebuttal statements and request the filing of written statements subsequent to the adjournment of the oral presentations.

3.5(4) *Additional information.* In addition to receiving written comments and oral presentations on a proposed rule according to the provisions of this rule, the department may obtain information concerning a proposed rule through any other lawful means deemed appropriate under the circumstances.

The department may send notices of proposed rule making and a request for comments to any agency, organization, or association known to it to have a direct interest or expertise pertaining to the substance of the proposed rule.

3.5(5) *Accessibility.* The department shall schedule oral proceedings in rooms accessible to and functional for persons with physical disabilities. Persons who have special requirements should contact the bureau of policy analysis at (515)281-8440 in advance to arrange access or other needed services.

441—3.6(17A) Regulatory analysis.

3.6(1) *Definition of small business.* A "small business" is defined in 1998 Iowa Acts, chapter 1202, section 10, subsection 7.

3.6(2) *Distribution list.* Small businesses or organizations of small businesses may be registered on the department's small business impact list by making a written application addressed to the Bureau of Policy Analysis, Department of Human Services, Hoover State Office Building, Des Moines, Iowa 50319-0114. The application for registration shall state:

a. The name of the small business or organization of small businesses;

b. Its address;

c. The name of a person authorized to transact business for the applicant;

d. A description of the applicant's business or organization. An organization representing 25 or more persons who qualify as a small business shall indicate that fact.

e. Whether the registrant desires copies of Notices of Intended Action at cost or via electronic transmission, or desires advance notice of the subject of all or some specific category of proposed rule making affecting small business.

3.16(2) *Conduct of review.* In conducting the formal review, the department shall prepare within a reasonable time a written report summarizing its findings, its supporting reasons, and any proposed course of action. The report shall include a concise statement of the department's findings regarding the rule's effectiveness in achieving its objectives, including a summary of any available supporting data. The report shall also concisely describe significant written criticisms of the rule received during the previous five years, including a summary of any requests for exceptions to the rule received by the department or granted by the department. The report shall describe alternative solutions to resolve the criticisms of the rule, the reasons any were rejected, and any changes made in the rule in response to the criticisms as well as the reasons for the changes. A copy of the department's report shall be sent to the administrative rules review committee and the administrative rules coordinator. The report shall also be available for public inspection.

These rules are intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202, and Iowa Code section 25B.6.

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h. Service and cost tracking. The plan administration section of the manual shall include a description of a system to track services and supports and payments made on behalf of all approved consumers. The tracking system shall provide an unduplicated consumer count and expenditure data. The tracking system shall also record denials of services and supports and indicate the reason why the applications were denied.

i. Service monitoring. The plan administration section of the manual shall outline the process of service and funding monitoring.

j. Appeals. The county shall develop and implement a process for appealing the decisions of the county or its agent. This appeal process shall be based on objective criteria, specify time frames, provide for notification in accessible formats of the decisions to all parties, and provide some assistance to consumers in using the process. Responsibility for the final administrative decision on an appeal shall not rest with the county board of supervisors. If the appellant has state case status, responsibility for the final administrative decision on an appeal shall rest with the department, following the procedures established in 441—Chapter 7.

25.13(3) *Management plan annual review.* The policies and procedures manual shall address the process for preparation and distribution of the management plan annual review.

25.13(4) *Three-year strategic plan.* The policies and procedures manual shall address the process for development and approval of the three-year strategic plan.

441—25.14(331) Policies and procedures manual review. The policies and procedures manual shall be submitted by April 1, 2000, as a part of the county's management plan for the fiscal year beginning July 1, 2000. The director, in consultation with the state-county management committee, shall review all county management plans submitted by the dates specified. Based on the recommendations of the state-county management committee, and if the director finds the county policies and procedures manual in compliance with these rules and state and federal laws, the director may approve the manual. A manual approved by the director for the fiscal year beginning July 1, 2000, shall remain in effect subject to amendment.

25.14(1) *Criteria for acceptance.* The director shall determine a manual is acceptable when it contains all the required information, meets the criteria described in this division, and is in compliance with all applicable state and federal laws. The director may request additional information to determine whether or not the manual contains all the required information and meets criteria described in this division.

25.14(2) *Notification.* Except as specified in subrule 25.14(3), the director shall notify the county in writing of the decision on the manual by June 1, 2000. The decision shall specify that either:

a. The manual is approved as it was submitted, either with or without supplemental information already requested and received.

b. The manual will not be approved until revisions are made. The letter will specify the nature of the revisions requested and the time frames for their submission. The director may authorize a county to continue operation, for up to 90 days, using the previously approved county management plan. The extension begins on July 1, 2000.

25.14(3) *Review of late submittals.* The director may review manuals not submitted by April 1, 2000, after all manuals submitted by that date have been reviewed. The director will proceed with the late submittals in a timely manner.

441—25.15(331) Amendments. An amendment to the manual shall be submitted to the department at least 45 days prior to the date of implementation. Prior to implementation of any amendment to the manual, the director must approve the amendment. When an amendment substantially changes a county's policies and procedures manual, the department shall present the amendment to the state-county management committee.

25.15(1) *Criteria for acceptance.* The director shall determine an amendment is acceptable when it contains all the required information and meets the criteria described in this division for the applicable part of the policies and procedures manual and is in compliance with all applicable state and federal laws. The director may request additional information to determine whether or not the amendment contains all the required information and meets criteria described in this division.

25.15(2) *Notification.* The director shall notify the county, in writing, of the decision on the amendment within 45 days of receipt of the amendment. The decision shall specify either that:

a. The amendment is approved as it was submitted, either with or without supplemental information already requested and received.

b. The amendment is not approved. The notification will include why the amendment is not approved.

441—25.16(331) Reconsideration. Counties dissatisfied with the director's decision on a manual or an amendment may file a letter with the director requesting reconsideration. The letter of reconsideration must be received within 30 working days of the date of the notice of decision and shall include a request for the director to review the decision and the reasons for dissatisfaction. Within 30 working days of the receipt of the letter requesting reconsideration, the director, in consultation with the state-county management committee, will review both the reconsideration request and evidence provided. The director shall issue a final decision, in writing.

441—25.17(331) Management plan annual review. The county shall prepare a management plan annual review for the county stakeholders, the department of human services and the state-county management committee. The management plan annual review shall be submitted to the department for informational purposes by December 1. The management plan annual review shall incorporate an analysis of the data associated with the services managed during the preceding fiscal year by the county or by a managed care entity on behalf of the county. The management plan annual review shall include, but not be limited to:

1. Progress toward goals and objectives.
2. Documentation of stakeholder involvement.
3. Actual provider network.
4. Actual expenditures.
5. Actual scope of services.
6. Number, type, and resolution of appeals.
7. Quality assurance implementation, findings and impact on plan.
8. Waiting list information.

441—25.18(331) Strategic plan. The strategic plan shall describe the county's vision for its mental health, mental retardation, and developmental disabilities system for the ensuing three fiscal years. The strategic plan development shall follow the process outlined in the policies and procedures manual. The strategic plan shall be submitted, for informational purposes, to the department by April 1, 2000, and by April 1 of every third year thereafter. The strategic plan shall include, but not be limited to:

25.18(1) *Needs assessment.* The strategic plan shall include an assessment of current needs. This plan shall describe how information from the annual reports from the previous years was incorporated into the current strategic plan and how the information will be used to develop future plans for the funding and provision of services to eligible groups.

25.18(2) *Goals and objectives.* The strategic plan shall list goals and objectives that are guided by the system principles of choice, empowerment, and community. The goals and objectives shall reflect the system which the county plans to have in place in three years, the action steps which will be taken to develop the future system, and how progress toward implementation will be measured. Projected costs for future projects should be included.

25.18(3) *Services and supports.* The strategic plan shall list services and supports that the county will fund, when requested, by eligibility group.

25.18(4) *Provider network.* The strategic plan shall include a list of providers used to provide the scope of services and supports described in the plan.

25.18(5) *Access points.* The strategic plan shall list designated access points and their function in the enrollment process.

441—25.19(331) Technical assistance. The department shall provide technical assistance and other necessary support to counties to assist in the development and implementation of the county management plans and completion of reports.

These rules are intended to implement Iowa Code sections 331.424A, 331.439, and 331.440.

441—25.20 to **25.40** Reserved.

DIVISION III
MINIMUM DATA SET

441—25.41(331) Minimum data set. Each county shall maintain data on all clients served through the MH/DD services fund. The type of information needed on each client is as follows:

1. Basic client information including a unique identifier, name, address, county of residence and county of legal settlement.
2. The state I.D. number for state payment cases.
3. Demographic information including, but not limited to, date of birth, sex, ethnicity, marital status, education, residential living arrangement, current employment status, monthly income, income sources, type of insurance, insurance carrier, veterans' status, guardianship status, legal status in the system, source of referral, DSM IV diagnosis, ICD-9 diagnosis, disability group (i.e., mental retardation, developmental disability, chronic mental illness, mental illness), central point of coordination (county number preceded by A 1), and central point of coordination (CPC) name.
4. Service information such as the decision on services, date of decision, date client terminated from CPC services, reason for termination, residence, approved service, service beginning dates, service ending dates, reason for terminating, approved units of services, and unit rate for service.

A county may choose to collect this information using the county management information system (CoMIS) program that was designed by the department or may collect the information through some other means. If a county chooses to use another system, the county must be capable of supplying the information in the same format. Below is the structure or description for each data item contained in CoMIS.

NAME	DESCRIPTION	SIZE	TYPE	ACCEPTABLE CODES/ENTRIES	REASON/USE
Client ID#	Client Identifier	F		Social Security Number	Unique identifier for each client/allows unduplicated client information
RESCO	County of Residence	F	N	00 through 99	Where the person lives
LEGCO	County of Legal Settlement	F	N	00 through 99	Who has financial responsibility
SID	State ID	F	A/N		Not required except for state payment cases
LNAME	Last name	F	A	Client's last name	CPC info
FNAME	First name	F	A	Client's first name	CPC info
MI	Middle initial	F	A	Client's middle initial	CPC info
ADD1	First address field	F	A/N		For local CPC use
ADD2	Second address field	F	A/N		For local CPC use
CITY	City/town	F	A		City where post office is located
STATE	State	F	A	State	State
ZIP	Postal Zip Code	F	N	5-Digit Zip	
BDATE	Date of Birth	F	N	Month/day/four-digit year	Demographic for planning
SEX	Sex	F	A	1=Male 2=Female	Demographic for planning

441—25.53(77GA,HF2545) Methodology for awarding incentive funding. Each county shall report on all performance measures listed in this division, plus any additional performance measures the county has selected, by December 1 of each year.

25.53(1) *Reporting.* Each county shall report performance measure information on forms, or by electronic means, developed for the purpose by the department in consultation with the state county management committee.

25.53(2) *Scoring.* The department shall analyze each county's report to determine the extent to which the county achieved the levels contained in the proposal accepted by the state county management committee. Prior to distribution of incentive funding to counties, results of the analysis shall be shared with the state county management committee.

25.53(3) *County ineligibility.* A county which does not report performance measure data by December 1 will be ineligible to receive incentive funds for that fiscal year. A county may apply for an extension by petitioning the state county management committee prior to December 1. The petition shall describe the circumstances which will cause the report to be delayed and identify the date by which the report will be submitted.

441—25.54(77GA,HF2545) Subsequent year performance factors. For any fiscal year which begins after July 1, 1999, the state county management committee shall not apply any additional performance measures until the county management information system (CoMIS) developed and maintained by the division of mental health and developmental disabilities has been modified, if necessary, to collect and calculate required data elements and performance measures and each county has been given the opportunity to establish baseline measures for those measures.

441—25.55(77GA,HF2545) Phase-in provisions.

25.55(1) *State fiscal year 1999.* For the fiscal year which begins July 1, 1998, each county shall collect data as required above in order to establish a baseline level on all performance measures. A county which collects and reports all required data by December 1, 1999, shall be deemed to have received a 100 percent score on the county's performance indicators.

25.55(2) *State fiscal year 2000.* A county which submits a proposal with its management plan for the fiscal year which begins July 1, 1999, and reports the levels achieved on the selected performance measures by December 1, 2000, shall be deemed to have received a 100 percent score on the county's performance indicators, regardless of the actual levels achieved.

These rules are intended to implement 1998 Iowa Acts, House File 2545, section 8, subsection 2.

441—25.56 to **25.60** Reserved.

DIVISION V
RISK POOL FUNDING

PREAMBLE

These rules establish a risk pool board to administer the risk pool fund established by the legislature and set forth the requirements for counties for receiving and repaying funding from the fund.

441—25.61(426B) Definitions.

"Aggregate application" means the request for funding when a county has an unanticipated net expenditure amount for mental health, mental retardation, and developmental disabilities services fund expenditures that would result in the county's current fiscal year budgeted net expenditure amount exceeding the sum of 105 percent of the county's current fiscal year budgeted net expenditure amount and the county's prior fiscal year accrual ending fund balance exceeding 25 percent of the prior fiscal year's net expenditure amount.

"Available pool" means those funds remaining in the risk pool less any actuarial and other direct administrative costs.

"Commission" means the mental health and developmental disabilities commission.

"Division" means the mental health and developmental disabilities division of the department of human services.

"Individual application" means the request for funding when a county has individuals who have unanticipated disability conditions with an exceptional cost and the individuals are either new to the county's service system or the individuals' disability conditions have changed or are new.

"Loan" means the risk pool funds a county received in a fiscal year in which the county did not levy the maximum amount allowed for the county's mental health, mental retardation, and developmental disabilities services fund under Iowa Code section 331.424A.

"Net expenditure amount" means a county's gross expenditures from the services fund for a fiscal year as adjusted by subtracting all services fund revenues for that fiscal year that are received from a source other than property taxes, as calculated on a modified accrual basis.

"Services fund" means a county's mental health, mental retardation, and developmental disabilities services fund created in Iowa Code section 331.424A.

441—25.62(426B) Risk pool board. This nine-member board consists of two county supervisors, two county auditors, a member of the state-county management committee created in Iowa Code section 331.438 who was not appointed by the Iowa state association of counties, a member of the county finance committee created in Iowa Code chapter 333A who is not an elected official, two single entry point process administrators, all appointed by the governor, subject to confirmation by two-thirds of the members of the senate, and one member appointed by the director of the department of human services.

25.62(1) *Organization.*

a. The members of the board shall annually elect from the board's voting membership a chairperson and vice-chairperson of the board.

b. Members appointed by the governor shall serve three-year terms.

25.62(2) *Duties and powers of the board.* The board's powers and duties are to make policy and to provide direction for the administration of the risk pool established by Iowa Code section 426B.5, subsection 3. In carrying out these duties, the board shall do all of the following:

a. Recommend to the commission for adoption rules governing the risk pool fund.

b. Determine application requirements to ensure prudent use of risk pool assistance.

c. Accept or reject applications for assistance in whole or in part.

d. Review the fiscal year-end financial records for all counties that are granted risk pool assistance and determine if repayment is required.

e. Approve actuarial and other direct administrative costs to be paid from the pool.

f. Perform any other duties as mandated by law.

25.62(3) *Board action.*

a. A quorum shall consist of two-thirds of the membership appointed and qualified to vote.

b. When a quorum is present, an action is carried by a majority of the qualified members of the board.

25.62(4) *Board minutes.*

a. Copies of administrative rules and other materials considered are made part of the minutes by reference.

b. Copies of the minutes are kept on file in the office of the administrator of the division of mental health and developmental disabilities.

25.62(5) *Board meetings.*

a. The board shall meet in April of each year and may hold special meetings at the call of the chairperson or at the request of a majority of the voting members.

b. Any county making application for risk pool funds must be represented at the board meeting when that request is considered. The division shall notify the county of the date, time and location of the meeting. Any other persons with questions about the date, time or location of the meeting may contact the Administrator, Division of Mental Health and Developmental Disabilities, Department of Human Services, Hoover State Office Building, Fifth Floor, 1305 East Walnut, Des Moines, Iowa 50309-0114, telephone (515)281-5874.

c. The board shall comply with applicable provisions of Iowa's open meetings law, Iowa Code chapter 21.

25.62(6) *Records.* Any records maintained by the board or on behalf of the board shall be made available to the public for examination in compliance with Iowa's open records law, Iowa Code chapter 22. To the extent possible, prior to submitting applications, records and documents, applicants shall delete any confidential information. These records shall be maintained in the office of the division of mental health and developmental disabilities.

25.62(7) *Conflict of interest.* A board member cannot be a part of any presentation to the board of that board member's county's application for risk pool funds nor can the board member be a part of any action pertaining to that application.

25.62(8) *Robert's Rules of Order.* In cases not covered by these rules, Robert's Rules of Order shall govern.

25.62(9) *Report.* On or before March 1 and September 1 of each fiscal year, the department of human services shall provide the risk pool board with a report of the financial condition of each funding source administered by the board. The report shall include, but is not limited to, an itemization of the funding source's balances, types and amount of revenues credited and payees and payment amounts for the expenditures made from the funding source during the reporting period.

441—25.63(426B) Application process.

25.63(1) *Applicants.* A county may make an aggregate or individual application at any time on or before April 1 of any given year for the current fiscal year budget whenever the projected net expenditure amount exceeds the sum of 105 percent of the county's current fiscal year budgeted net expenditure amount and the county's prior fiscal year accrual ending fund balance exceeds 25 percent of the prior fiscal year's net expenditure. However, if a county's services fund ending balance in the previous fiscal year was less than 10 percent of the amount of the county's gross expenditures from the services fund for that fiscal year and the county has a projected net expenditure amount for the current fiscal year that is in excess of 101 percent of the budgeted net expenditure amount for the current fiscal year, the county shall be considered to have met the basic eligibility requirement and is qualified for risk pool assistance.

The purpose of the mental health risk pool is to assist counties whose expenditures in the services fund exceed budgeted costs due to unanticipated expenses for new individuals or other unexpected factors. The mental health risk pool is not intended for multiyear usage or as a source of planned revenue.

25.63(2) *Application procedures.* The county shall send Form 470-3723, Risk Pool Application, plus 15 copies, to the division. The division must receive the application no later than 4:30 p.m. on April 1 of each year; or, if April 1 is a holiday, a Saturday or Sunday, the division must receive the application no later than 4:30 p.m. on the first working day thereafter. Facsimiles and electronic mail are not acceptable. The application shall be signed and dated by both the chairperson of the county board of supervisors and the central point of coordination administrator. Staff of the division shall notify each county of receipt of the county's application.

The county shall attach the following forms to the application:

a. Form 634A, Revenues Detail.

b. Form 634B, Service Area Detail (pages 1 to 10).

c. Form 634C, Service Area 4 Supporting Detail (pages 1 to 8).

d. Form 638R, Statement of Revenues, Expenditures, and Changes in Fund Balance—Actual and Budget (pages 1 and 2).

e. If the budget has been amended, Form 653A-R, Record of Hearing and Determination on the Amendment to County Budget (sheet 2), for both the current fiscal year budget, as last amended, and the prior fiscal year gross services fund expenditures.

25.63(3) *Request for additional information.* Staff shall review all applications for completeness. If an application is not complete, staff of the division shall contact the county within four working days after April 1 or the first working day thereafter, if April 1 is a holiday, a Saturday or Sunday, to request the information needed to complete the application. The county shall submit the required information within five working days from the date of the division's request for the additional information.

441—25.64(426B) Methodology for awarding risk pool funding.

25.64(1) *Notice of decision.* The risk pool board shall send a notice of decision of the board's action to the chairperson of the applying county's board of supervisors. Copies of the notice of decision shall be sent to the county auditor and the central point of coordination administrator.

25.64(2) *Distribution of funds.* The total amount of the risk pool shall be limited to the available pool for a fiscal year. If the total dollar amount of the approved applications exceeds the available pool, the board shall prorate the amount paid for an approved application. The funds will be prorated to each county based upon the proportion of each approved county's request to the total amount of all approved requests.

441—25.65(426B) Repayment provisions.

25.65(1) *Required repayment.* Counties shall be required to repay risk pool funds in the following situations:

a. A loan was granted to the county because the county did not levy the maximum amount allowed for the county's services fund under Iowa Code section 331.424A. The county shall be required to repay the risk pool loan funds during the two succeeding fiscal years, with at least 50 percent due in the first succeeding fiscal year and the remainder due in the second succeeding fiscal year. The repayment amount shall be limited to the amount by which the actual amount levied was less than the maximum amount allowed.

b. The county had levied the maximum amount allowed for the county's mental health, mental retardation, and developmental disabilities services fund, but the county's actual need for risk pool assistance was less than the amount of risk pool assistance granted to the county. The county shall refund the difference between the amount of assistance granted and the actual need.

25.65(2) *Year-end report.* Each county granted risk pool funds shall complete a year-end financial report. The division shall review the accrual information and notify the mental health risk pool board if any county that was granted assistance in the prior year received more than the county's actual need based on the submitted financial report.

25.65(3) *Notification to county.* The chairperson of the mental health risk pool board shall notify each county by January 1 of each fiscal year of the amount to be reimbursed. The county shall reimburse the risk pool within 30 days of receipt of notification by the chairperson of the mental health risk pool board. If a county fails to reimburse the mental health risk pool, the board may request a revenue offset through the department of revenue and finance. Copies of the overpayment and request for reimbursement shall be sent to the county auditor and the central point of coordination administrator of the county.

441—25.66(426B) Appeals. The risk pool board may accept or reject an application for assistance from the risk pool fund in whole or in part. The decision of the board is final and is not appealable.

These rules are intended to implement Iowa Code section 426B.5, subsection 3.

441—25.67 to **25.70** Reserved.

DIVISION VI
TOBACCO SETTLEMENT FUND RISK POOL FUNDING

PREAMBLE

These rules provide for use of an appropriation from the tobacco settlement fund to establish a risk pool fund which may be used by counties with limited county mental health, mental retardation and developmental disabilities services funds to pay for increased compensation of the service staff of eligible purchase of service (POS) providers and establish the requirements for counties for receiving and repaying the funding. Implementation of the rate increases contemplated by the tobacco settlement fund in a timely manner will require cooperation among all eligible counties and providers.

441—25.71(78GA,ch1221) Definitions.

"Adjusted actual cost" means a POS provider's cost as computed using the financial and statistical report for the provider's fiscal year which ended during the state fiscal year beginning July 1, 1998 (state fiscal year 1999), as adjusted by multiplying those actual costs by 103.4 percent or the percentage adopted by the risk pool board in accordance with 2000 Iowa Acts, chapter 1221, section 3, subsection 3, paragraph *"c."*

"Department" means the Iowa department of human services.

"Division" means the mental health and developmental disabilities division of the department of human services.

"Financial and statistical report" means a report prepared by a provider and submitted to host counties that is prepared in accordance with department rules for cost determination set forth in 441—Chapter 150.

"Host county" means the county in which the primary offices of a POS provider are located. However, if a POS provider operates separate programs in more than one county, "host county" means each county in which a separate program is operated.

"Purchase of service provider" or *"POS provider"* means a provider of sheltered work, work activity, supported employment, job placement, enclave services, adult day care, transportation, supported community living services, or adult residential services paid by a county from the county's services fund created in Iowa Code section 331.424A under a state purchase of service or county contract.

"Risk pool board" means that board established by Iowa Code section 426B.5, subsection 3.

"Separate program" means a POS service operated in a county other than the county in which the provider's home office is located and for which the provider allocates costs separately from similar programs located in the county where the provider's home office is located.

"Services fund" means the fund defined in Iowa Code section 331.424A.

"Tobacco settlement fund loan" or *"TSF loan"* means the tobacco settlement fund risk pool funds a county received in a fiscal year in which the county did not levy the maximum amount allowed for the county's mental health, mental retardation, and developmental disabilities services fund under Iowa Code section 331.424A. The repayment amount shall be limited to the amount by which the actual amount levied was less than the maximum amount allowed.

441—25.72(78GA,ch1221) Risk pool board. The risk pool board is organized and shall take action and keep minutes and records as set out in rule 441—25.62(426B).

A risk pool board member cannot be a part of any presentation to the board of that board member's county's application for tobacco settlement fund risk pool funds nor can the board member be a part of any action pertaining to that application. If a risk pool board member is employed by or is a board member of a POS provider whose increases in compensation caused the host county to apply to the fund, the board member cannot be a part of any presentation to the board nor can the board member be a part of any action pertaining to that application.

441—25.73(78GA,ch1221) Rate-setting process. For services provided on or after July 1, 2000, each county shall increase its reimbursement rates for each program to the lesser of the adjusted actual cost or 105 percent of the rate paid for services provided on June 30, 2000.

25.73(1) *Financial and statistical report.* Each provider of POS services shall submit a financial and statistical report to each host county for each program that the provider operates within that county. These reports shall include actual costs for each separate program for the provider's fiscal year that ended during state fiscal year 1999 and state fiscal year 2000. These reports shall be submitted to the central point of coordination (CPC) administrator of the host county or counties no later than August 15, 2000.

25.73(2) *Rate determination.* The CPC administrator in each host county shall receive and review provider financial and statistical reports for each separate program for which that county is the host county. If the host county determines that all or part of the provider's increase in costs is attributable to increases in service staff compensation and that the adjusted actual cost is more than the rate paid by the county on June 30, 2000, the CPC administrator shall notify the provider in writing of the new rate for each program no later than September 1, 2000.

If a rate paid for services provided on June 30, 2000, exceeds the adjusted actual cost, the county shall not be required to adjust the rate for services provided on or after July 1, 2000.

The provider shall, no later than September 11, 2000, send to the CPC administrator of any other counties with consumers in those programs a copy of the rate determination signed by the CPC administrator of the host county. A county may delay payment of the reimbursement rate established pursuant to this subrule until the risk pool board has completed action as to adopting or not adopting a different percentage for the definition of adjusted actual cost, provided however that any increased rates required by 2000 Iowa Acts, chapter 1221, section 3, subsection 2, paragraph *"c,"* shall be paid retroactively for all services provided on or after July 1, 2000.

25.73(3) *Exemptions.*

a. A POS provider that has negotiated a reimbursement rate increase with a host county as of July 1, 2000, has the option of exemption from the provisions of these rules. However, a county shall not be eligible to receive tobacco settlement funds for any rates established outside of the process established in these rules.

b. Nothing in these rules precludes a county from increasing reimbursement rates of POS providers by an amount that is greater than that specified in these rules. However, a county shall not be eligible for tobacco settlement funds for the amount of any rate increase in excess of the amount established pursuant to these rules.

441—25.74(78GA,ch1221) Application process.

25.74(1) *Who may apply.* If a county determines that payment of POS provider rates in accordance with these rules will cause the county to expend more funds in FY2001 than budgeted for POS services, the county may apply for assistance from the tobacco settlement fund. However, any fiscal year 2000 projected accrual basis fund balances in excess of 25 percent of fiscal year 2000 services fund gross expenditures will reduce the amount for which a county is eligible. In considering the cost of implementing these provisions, a county shall not include the cost of rate increases granted to any providers who fail to complete financial and statistical reports as provided in these rules.

25.74(2) *How to apply.* The county shall send the original and 15 copies of Form 470-3768, Tobacco Settlement Fund Risk Pool Application, to the division. The division must receive the application no later than 4:30 p.m. on September 25, 2000. Facsimiles and electronic mail are not acceptable. The application shall be signed and dated by the chairperson of the county board of supervisors, the county auditor, and the CPC administrator. Staff of the division shall notify each county of receipt of the county's application.

25.74(3) *Request for additional information.* Staff shall review all applications for completeness. If an application is not complete, staff of the division shall contact the county by October 5, 2000, and request the information needed to complete the application. The county shall submit the required information by October 16, 2000.

441—25.75(78GA,ch1221) Methodology for awarding tobacco settlement fund risk pool funding.

25.75(1) *Review of applications.* The risk pool board shall review all of the applications from counties for assistance from the tobacco settlement fund. If the total amount requested from the tobacco settlement fund does not exceed $2 million, eligible counties shall be awarded funding pursuant to this division. The risk pool board shall determine for each county whether any or all of the assistance granted to that county is a TSF loan.

25.75(2) *Notice of decision.* The risk pool board shall notify the chair of the applying county's board of supervisors of the board's action no later than November 3, 2000. Copies shall be sent to the county auditor and the CPC administrator.

25.75(3) *Distribution of funds.* The total amount of the risk pool shall be limited to $2 million. If the total dollar amount of the eligible applications exceeds the available pool, the risk pool board shall revise the percentage adjustment to actual cost to arrive at adjusted actual cost as defined in this division and prorate funding to the eligible counties. If it becomes necessary to revise the percentage adjustment used to determine adjusted actual cost, the risk pool board shall determine if applicant counties remain eligible under this program.

25.75(4) *Notification of adjustment.* If the risk pool board rolls back the percentage adjustment used to determine adjusted actual cost, the risk pool board shall notify the chair of the board of supervisors of all counties, and copies shall be sent to the county auditor and the CPC administrator of each county. Each host county shall recalculate the reimbursement rate under this division using the revised adjusted actual cost percentage and notify each provider in writing of the revised rate within 30 days of receiving notice of the percentage adjustment. The provider shall, within 30 days of receipt of notice, send to the CPC administrator of any other counties with consumers in those programs a copy of the revised rate determination signed by the CPC administrator of the host county.

441—25.76(78GA,ch1221) Repayment provisions.

25.76(1) *Required repayment.* Counties shall be required to repay TSF loans by January 1, 2002. Repayments shall be credited to the tobacco settlement fund.

25.76(2) *Notification to county.* In the notice of decision provided pursuant to these rules, the chairperson of the risk pool board shall notify each county of the portion, if any, of the assistance that is considered a TSF loan. If a county fails to reimburse the tobacco settlement fund by January 1, 2002, the board may request a revenue offset through the department of revenue and finance. Copies of the overpayment and request for reimbursement shall be sent to the county auditor and the CPC administrator of the county.

441—25.77(78GA,ch1221) Appeals. The risk pool board may accept or reject an application for assistance from the tobacco settlement fund risk pool fund in whole or in part. The decision of the board is final and is not appealable.

These rules are intended to implement 2000 Iowa Acts, chapter 1221, section 3, as amended by chapter 1232, section 4.

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CHAPTER 26
COUNTY MAINTENANCE OF EFFORT CALCULATIONS AND REPORTING
Rescinded IAB 5/5/99, effective 7/1/99

CHAPTER 27
Reserved

◊Two ARCs

(3) A parent whose absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States is considered absent from the home, notwithstanding the provisions of subrule 41.22(5). "Uniformed service" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

b. The needs of an individual who is temporarily out of the home are included in the eligible group, if otherwise eligible. A temporary absence exists in the following circumstances:

(1) An individual is anticipated to be in the medical institution for less than a year, as verified by a physician's statement. Failure to return within one year will result in the individual's needs being removed from the grant.

(2) An individual is out of the home to secure education or training, as defined for children in 41.24(2)*"e"* and for adults in 441—subrule 93.114(1), first sentence, as long as the caretaker relative retains supervision of the child.

(3) An individual is out of the home for reasons other than reasons in subparagraphs (1) and (2) and the payee intends that the individual will return to the home within three months. Failure to return within three months will result in the individual's needs being removed from the grant.

41.23(4) *Citizenship and alienage for persons entering the United States before August 22, 1996.* Rescinded IAB 10/4/00, effective 12/1/00.

41.23(5) *Citizenship and alienage.*

a. A family investment program assistance grant may include the needs of a citizen or national of the United States, or a qualified alien as defined at 8 United States Code Section 1641. A person who is a qualified alien as defined at 8 United States Code Section 1641 is not eligible for family investment program assistance for five years. The five-year period of ineligibility begins on the date of the person's entry into the United States with a qualified alien status as defined at 8 United States Code Section 1641.

EXCEPTIONS: The five-year prohibition from family investment program assistance does not apply to qualified aliens described in 8 United States Code Section 1612, or to qualified aliens as defined at 8 United States Code Section 1641 who entered the United States before August 22, 1996. A person who is not a United States citizen or is not a qualified alien as defined at 8 United States Code Section 1641 is not eligible for the family investment program regardless of the date the person entered the United States.

b. As a condition of eligibility each recipient shall complete and sign Form 470-2549, Statement of Citizenship Status, attesting to the recipient's citizenship or alien status, when the statement has not previously been signed on the application. The form shall be signed by the recipient, or when the recipient is incompetent or incapacitated, someone acting responsibly on the recipient's behalf. When both parents are in the home, both shall sign the form. An adult recipient shall sign the form for dependent children. Failure to sign Form 470-2549 when required to do so creates ineligibility for the entire eligibility group.

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

441—41.24(239B) Promoting independence and self-sufficiency through employment job opportunities and basic skills (PROMISE JOBS) program. An application for assistance constitutes a registration for the program for all members of the family investment program (FIP) case. Persons in any FIP case who are not exempt from referral to PROMISE JOBS shall enter into a family investment agreement (FIA) as a condition of receiving FIP, except as described at 41.24(8).

41.24(1) *Referral to PROMISE JOBS.*

a. All persons whose needs are included in a grant under the FIP program shall be referred to PROMISE JOBS as FIA-responsible persons unless the county office determines the persons are exempt.

b. Any parent living in the home of a child receiving a grant shall also be referred to PROMISE JOBS as an FIA-responsible person unless the county office determines the person is exempt.

c. Except for persons described at paragraph 41.24(2)*"f,"* persons determined exempt from referral, including applicants, may volunteer for PROMISE JOBS.

d. Applicants who have chosen and are in a limited benefit plan that began on or after June 1, 1999, shall complete significant contact with or action in regard to PROMISE JOBS as described at paragraphs 41.24(8)*"a"* and *"d"* for FIP eligibility to be considered. For two-parent households, both parents must participate as previously stated except when one parent meets the exemption criteria described at subrule 41.24(2).

41.24(2) *Exemptions.* Except as specified at subrule 41.30(3), the following persons are exempt from referral:

a. and *b.* Rescinded IAB 12/3/97, effective 2/1/98.

c. A person who is under the age of 16 and is not a parent.

d. A person who is disabled, according to the Americans with Disabilities Act, and unable to participate. Medical evidence of disability may be obtained from either an independent physician or psychologist or the state rehabilitation agency.

(1) The evidence may be submitted either by letter from the physician or on Form 470-0447, Report on Incapacity.

(2) When an examination is required and other resources are not available to meet the expense of the examination, the physician shall be authorized to make the examination and submit the claim for payment on Form 470-0502, Authorization for Examination and Claim for Payment.

(3) A finding of eligibility for social security benefits or supplemental security income benefits based on disability or blindness is acceptable proof of disability for family investment program purposes.

e. A person who is aged 16 to 19, and is not a parent, who attends an elementary, secondary or equivalent level of vocational or technical school full-time.

(1) A person shall be considered to be attending school full-time when enrolled or accepted in a full-time (as certified by the school or institute attended) elementary, secondary or the equivalent level of vocational or technical school or training leading to a certificate or diploma. Correspondence school is not an allowable program of study.

(2) A person shall also be considered to be in regular attendance in months when the person is not attending because of an official school or training program vacation, illness, convalescence, or family emergency. A child meets the definition of regular school attendance until the child has been officially dropped from the school rolls.

(3) When a person's education is temporarily interrupted pending adjustment of the education or training program, exemption shall be continued for a reasonable period of time to complete the adjustment.

f. A person who is not a United States citizen and is not a qualified alien as defined in 8 United States Code Section 1641.

(3) Income maintenance shall determine eligibility for a hardship exemption.

(4) The family shall provide supporting evidence of the hardship barrier and the impact of the barrier upon the family's ability to leave FIP. The county office shall advise the applicant or recipient about how to obtain necessary documents. Upon request, the county office shall provide reasonable assistance in obtaining supporting documents when the family is not reasonably able to obtain the documents. The type of supporting evidence is dependent upon the circumstance that creates the hardship barrier.

(5) Examples of types of supporting evidence may include:

1. Court, medical, criminal, child protective services, social services, psychological, or law enforcement records.
2. Statements from professionals or other individuals with knowledge of the hardship barrier.
3. Statements from vocational rehabilitation or other job training professionals.
4. Statements from individuals other than the applicant or recipient with knowledge of the hardship circumstances. Written statements from friends and relatives alone may not be sufficient to grant hardship status, but may be used to support other evidence.
5. Court, criminal, police records or statements from domestic violence counselors may be used to substantiate hardship. Living in a domestic violence shelter shall not automatically qualify an individual for a hardship exemption, but would be considered strong evidence.

(6) The county office shall notify the family in writing of additional information or verification that is required to verify the barrier and its impact upon the family's ability to leave FIP. The family shall be allowed ten days to supply the required information or verification. The ten-day period may be extended under the circumstances described in 441—subrule 40.24(1) or 441—paragraph 40.27(4)*"c."* Failure to supply the required information or verification, or refusal by the family to authorize the county office to secure the information or verification from other sources, shall result in denial of the family's request for a hardship exemption.

(7) Rescinded IAB 12/12/01, effective 11/14/01.

(8) Rescinded IAB 12/12/01, effective 11/14/01.

(9) Recipients whose FIP assistance is canceled at the end of the sixtieth month shall be eligible for reinstatement as described at 441—subrule 40.22(5) when Form 470-3826 is received before the effective date of cancellation even if eligibility for a hardship exemption is not determined until on or after the effective date of cancellation.

(10) When Form 470-3826 is not received before the effective date of the FIP cancellation and a Public Assistance Application is required for the family to regain FIP eligibility, the effective date of assistance shall be no earlier than seven days from the date of application as described at rule 441—40.26(239B).

(11) Eligibility for a hardship exemption shall last for six consecutive calendar months. EXCEPTION: The six-month hardship exemption ends when FIP for the family is canceled for any reason and a Public Assistance Application is required for the family to regain FIP eligibility. In addition, when FIP eligibility depends on receiving a hardship exemption, the family shall submit a new Form 470-3826. A new hardship exemption determination shall be required prior to FIP approval.

(12) FIP received for a partial month of the six-month hardship exemption period shall count as a full month.

(13) There is no limit on the number of hardship exemptions a family may receive over time.

e. Six-month family investment agreement (FIA). Families who request a hardship exemption shall develop and sign a six-month family investment agreement (FIA) as defined at rule 441—93.109(239B) to address the circumstances that are creating the barrier. All adults as defined in subrule 41.30(1) shall sign the six-month FIA. The six-month FIA shall contain specific steps to enable the family to make incremental progress toward overcoming the barrier. Each subsequent hardship exemption shall require a new six-month FIA. Failure to develop or sign a six-month FIA shall result in denial of the family's hardship exemption request.

Families shall be notified in writing of any scheduled interview to develop the six-month FIA. Families shall be allowed at least five working days from the date the notice is mailed toattend this scheduled interview. Failure to attend a scheduled interview as required, except for reasons beyond the adult's control, shall result in a denial of the family's hardship exemption request. In two-parent families, both parents shall be required to participate in any scheduled interview. When the adult is incompetent or incapacitated, someone acting responsibly on the adult's behalf may participate in the interview.

(1) PROMISE JOBS staff shall provide necessary supportive services as described in 441—Chapter 93 and shall monitor the six-month FIA. Periodic contacts shall be made with the family at least once a month. These contacts need not be in person. Time and attendance reports shall be required as specified at rule 441—93.135(239B).

(2) The six-month FIA shall be renegotiated and amended under the circumstances described at 441—subrule 93.109(2).

(3) Any family that has been granted a hardship exemption and that does not follow the terms of the family's six-month FIA will have chosen a limited benefit plan in accordance with 441—Chapters 41 and 93.

f. Any family that is denied a hardship exemption may appeal the decision as described in 441—Chapter 7.

This rule is intended to implement Iowa Code chapter 239B.

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CHAPTER 42
UNEMPLOYED PARENT

[Prior to 7/1/83, Social Services[770] Ch 42]
[Prior to 2/11/87, Human Services[498]]
Rescinded IAB 11/1/00, effective 1/1/01

CHAPTER 46
OVERPAYMENT RECOVERY

[Prior to 7/1/83, Social Services[770] Ch 46]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP
[Rescinded IAB 2/12/97, effective 3/1/97]

441—46.1 to **46.20** Reserved.

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP
[Prior to 10/13/93, 441—46.1(239) to 46.8(239)]

441—46.21(239B) Definitions.

"Agency error" in overpayments means: (a) The same as circumstances described in 441—subrule 45.24(1) pertaining to underpayments, or (b) any error that is not a client or procedural error.

"Client" means a current or former applicant or recipient of the family investment program.

"Client error" means and may result from:

False or misleading statements, oral or written, regarding the client's income, resources, or other circumstances which may affect eligibility or the amount of assistance received;

Failure to timely report changes in income, resources, or other circumstances which may affect eligibility or the amount of assistance received;

Failure to timely report the receipt of and, if applicable, to refund assistance in excess of the amount shown on the most recent Notice of Decision, Form 470-0485(C) or 470-0486(M), or the receipt of a duplicate grant; or

Failure to refund to the child support recovery unit any nonexempt payment from the absent parent received after the date the decision on eligibility was made.

"Intentional program violation" is an action by a person for the purpose of establishing or maintaining the family's eligibility for FIP, or for increasing or preventing reduction in the grant amount by intentionally (1) making a false or misleading statement; (2) misrepresenting, concealing or withholding facts; or (3) acting with the intent to mislead, misrepresent, conceal or withhold facts, or provide false information.

"Overpayment" means any assistance payment received in an amount greater than the amount the eligible group is entitled to receive.

"Procedural error" means a technical error that does not in and of itself result in an overpayment. Procedural errors include:

Failure to secure a properly signed application at the time of initial application or reapplication.

Failure to secure a properly signed Form 470-3826, Request for FIP Beyond 60 Months, as described at 441—subrule 41.30(3).

Failure of the county office to conduct the face-to-face interviews described in 441—subrules 40.24(2) and 40.27(1).

Failure to request a Public Assistance Eligibility Report or a Review/Recertification Eligibility Document at the time of a monthly, semiannual, or annual review.

Failure of county office staff to cancel the family investment program when the client submits a Public Assistance Eligibility Report or a Review/Recertification Eligibility Document which is not complete as defined in 441—paragraph 40.27(4)*"b."* However, overpayments of grants as defined above based on incomplete reports are subject to recoupment.

"Recoup" means reimburse, return, or repay an overpayment.

"Recoupment" means the repayment of an overpayment, either by a payment from the client or an amount withheld from the assistance grant or both.

441—46.22(239B) Monetary standards.

46.22(1) *Amount subject to recoupment.* All family investment program overpayments shall be subject to recoupment.

46.22(2) *Grant issued.* When recoupment is made by withholding from the family investment program grant, the grant issued shall be for no less than $10.

441—46.23(239B) Notification and appeals. All clients shall be notified by the department of inspections and appeals, as described at 441—subrule 7.5(6), when it is determined that an overpayment exists. Notification shall include the amount, date and reason for the overpayment. The local office shall provide additional information regarding the computation of the overpayment upon the client's request. The client may appeal the computation of the overpayment and any action to recover the overpayment through benefit reduction in accordance with 441—subrule 7.5(6).

441—46.24(239B) Determination of overpayments. All overpayments due to agency or client error or due to assistance paid pending an appeal decision shall be recouped. A procedural error alone does not result in an overpayment.

46.24(1) *Agency error.* When an overpayment is due to an agency error, recoupment shall be made, including those instances when errors by the department prevent the requirements in 441—subrule 41.22(6) or 41.22(7) from being met or when the client receives a duplicate grant. An overpayment of any amount is subject to recoupment with one exception: When the client receives a grant that exceeds the amount on the most recent notice from the department, recoupment shall be made only when the amount received exceeds the amount on the notice by $10 or more. The client is required to timely report receipt of excess assistance under 441—subrule 40.27(4). An overpayment due to agency error shall be computed as if the information had been acted upon timely.

46.24(2) *Assistance paid pending appeal decision.* Recoupment of overpayments resulting from assistance paid pending a decision on an appeal hearing shall begin no later than the month after the month in which the final decision is issued.

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441—77.10(249A) Medical equipment and appliances, prosthetic devices and sickroom supplies. All dealers in medical equipment and appliances, prosthetic devices and sickroom 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) Skilled nursing homes. Rescinded IAB 7/10/91, effective 9/1/91.

441—77.13(249A) Hearing aid dealers. Hearing aid dealers are eligible to participate if they are duly licensed by the state of Iowa. Hearing aid dealers 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. Applications to participate shall be directed to the Division of Medical Services, Hoover State Office Building, Des Moines, Iowa 50319-0114.

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) Genetic consultation clinics. Rescinded IAB 6/28/00, effective 8/2/00.

441—77.26(249A) Nurse-midwives. Advanced registered nurse practitioners are eligible to participate in the Medicaid program if they are duly licensed by the state of Iowa and if they possess evidence of certification as a nurse-midwife as set forth in board of nursing rules 655—Chapter 7. Advanced registered nurse practitioners in other states shall be eligible to participate if they are duly licensed in that state and they possess evidence of certification to practice as a nurse-midwife according to the standards imposed by that state.

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

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 department of education.

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.* Providers shall meet the standards in 441—Chapter 186 when providing child welfare targeted case management services as defined in 441—Chapter 186.

441—77.30(249A) HCBS ill and handicapped waiver service providers. The following HCBS ill and handicapped waiver service providers shall be eligible to participate in the Medicaid program provided that they meet the standards set forth below:

77.30(1) *Homemaker providers.* Homemaker providers shall be agencies which meet the home care standards and requirements set forth in department of public health rules, 641—80.5(135), 641—80.6(135), and 641—80.7(135) or which are certified as a home health agency under Medicare.

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 meet one of the following conditions:

a. The provider shall have a contract with the Veterans Administration to provide adult day health care.

b. The provider shall meet one of the following conditions individually or as an integral service provided by an organization:

(1) Accreditation by the Joint Commission on Accreditation of Health Care Organizations.

(2) Accreditation by the Commission on Accreditation of Rehabilitation Agencies.

(3) Rescinded IAB 3/10/99, effective 5/1/99.

(4) Existence of a contract with or receipt of a point-in-time letter of certification from the department of elder affairs or an area agency on aging pursuant to standards set forth in department of elder affairs rules 321—24.1(231) to 321—24.8(231).

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 HCBS MR 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 (RCF/PMR) licensed 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.

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 service providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the consumer 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 consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the consumer or a parent or stepparent of a consumer aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on the behalf of a consumer who receives home- and community-based services.

b. Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in department of public health rules 641—80.5(135), 641—80.6(135), and 641—80.7(135).

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 voluntarily accredited or certified by the department of elder affairs.

h. Adult day service providers that meet the conditions of participation for adult day care providers as specified at 441—subrule 77.30(3), 77.33(1), 77.34(7), or 77.39(20) and that have provided a point-in-time letter of notification from the department of elder affairs or an area agency on aging stating the adult day service provider also meets the requirements of department of elder affairs rules in 321—Chapter 25.

77.39(25) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Licensed child care centers.

(2) Registered group child care homes.

(3) Registered family child care homes.

(4) Home health agencies certified to participate in the Medicare program.

(5) Supported community living providers certified according to subrule 77.37(14).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to consumers shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the consumer or a parent or stepparent of the consumer if the consumer is aged 17 or under.

(3) Not be a usual caregiver of the consumer.

(4) Be qualified by training or experience, as determined by the usual caregivers and a licensed medical professional on the consumer's interdisciplinary team and documented in the service plan, to provide medical intervention or intervention in a medical emergency necessary to carry out the consumer's plan of care.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to consumers. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

441—77.40(249A) Lead inspection agency providers. Lead inspection agency providers are eligible to participate in the Medicaid program if they are certified pursuant to 641—subrule 70.5(5), department of public health.

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

441—77.41(249A) HCBS physical disability waiver service providers. Consumer-directed attendant care, home and vehicle modification, personal emergency response system, specialized medical equipment, and transportation service providers shall be eligible to participate as approved physical disability waiver service providers in the Medicaid program based on the applicable subrules pertaining to the individual service. Enrolled providers shall maintain the certification listed in the applicable subrules in order to remain eligible providers.

77.41(1) *Enrollment process.* Reviews of compliance with standards for initial enrollment shall be conducted by the department's division of medical services 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 consumer 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 consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse or guardian of the consumer.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a consumer who receives home- and community-based services.

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) *Compliance with department of education rules and licensure requirements.* These providers must comply with applicable requirements under the department of education rules set forth at 281—41.8(256B,34CFR300), 281—41.9(256B,273,34CFR300), and 281—41.10(256B) and board of educational examiners rules at 282—subrules 14.20(5) and (6), and services must be rendered by practitioners who meet any applicable professional licensure requirements.

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.

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

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

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

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

78.1(1) Payment will not be made for:

a. Drugs dispensed by a physician or other legally qualified practitioner (dentist, podiatrist, 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. A routine physical examination is an examination performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury. No payment will be made for these examinations unless:

(1) The examination is required as a condition of employment or training and is approved by the department.

(2) The examination is required for an initial certification or period of recertification of the need for nursing care.

(3) The examination is in connection with early and periodic screening, diagnosis, and treatment for persons under age 21, as specified in rules 441—78.18(249A) and 441—84.3(249A).

(4) The examination is required of a child or disabled adult for attendance at school or camp. These examinations shall include all components necessary to meet all early and periodic screening, diagnosis and treatment requirements as set forth in rules 441—78.18(249A) and 441—84.3(249A).

(5) The examination is in connection with the prescription of birth control medications and devices.

(6) The examination is for a pap smear which is allowed as preventive medicine services.

(7) The examination is for well baby care or a routine physical examination for a child under six years of age. These examinations shall include all components necessary to meet all early and periodic screening, diagnosis and treatment requirements as set forth in rules 441—78.18(249A) and 441—84.3(249A).

(8) The examination is an annual routine physical examination for a child in foster care for whom the department assumes financial responsibility. These examinations shall include all components necessary to meet all early and periodic screening, diagnosis and treatment requirements as set forth in rules 441—78.18(249A) and 441—84.3(249A).

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) Payment will be made for drugs and supplies when prescribed by a legally qualified practitioner (physician, dentist, podiatrist, therapeutically certified optometrist, physician assistant, or advanced registered nurse practitioner) as provided in this rule.

a. Prescription drugs.

(1) Subject to subparagraphs (2) and (3), payment will be made for prescription drugs 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.

(2) Notwithstanding subparagraph (1), payment is not made for: drugs if the prescribed use is not for a medically accepted indication as defined by Section 1927(k)(6) of the Social Security Act; drugs used to cause anorexia, weight gain, or weight loss (except for lipase inhibitor drugs for weight loss, with prior authorization as provided in subparagraph (3) below); drugs used for cosmetic purposes or hair growth; drugs used to promote smoking cessation; 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; drugs described in Section 107(c)(3) of the Drug Amendments of 1962; identical, similar, or related drugs (within the meaning of Section 310.6(b)(1) of Title 21 of the Code of Federal Regulations (DESI drugs)); and drugs which are prescribed for an individual for fertility purposes. Exceptions may be made to allow payment for fertility drugs if prescribed for a use that meets the definition of a medically accepted indication as described previously in this subparagraph.

(3) Payment will be made for certain drugs only when prior approval is obtained from the fiscal agent and when prescribed for treatment of specified conditions as follows. Prior authorization will be granted for 12-month periods per recipient as needed unless otherwise specified.

Prior authorization is required for psychostimulants for recipients 21 years of age or older. Prior approval shall be granted if there is documentation of one of the following:

1. Attention deficit disorder.
2. Attention deficit hyperactivity disorder.
3. Narcolepsy.
4. Adjunctive treatment of major depression.

The fiscal agent shall consider other conditions on an individual basis after review of documentation submitted regarding the need for psychostimulants. Psychostimulants include the following medications: dextroamphetamine, amphetamine mixtures, methamphethamine, methylphenidate, pemoline (Cylert), and modafinil (Provigil). (Cross-reference 78.28(1)*"a"*)

Payment for multiple vitamins, tonic preparations and combinations thereof with minerals, hormones, stimulants, or other compounds which are available as separate entities for treatment of specific conditions will be approved when there is a specifically diagnosed vitamin deficiency disease or for recipients aged 20 or under if there is a diagnosed disease which inhibits the nutrition absorption process secondary to the disease. (Prior approval is not required for products principally marketed as prenatal vitamin-mineral supplements.) (Cross-reference 78.28(1)"*b*")

Full therapeutic dose levels and maintenance dose levels for the following drugs are those listed in the American Hospital Formulary Service Drug Information, United States Pharmacopeia-Drug Information, American Medical Association Drug Evaluations, and the peer-reviewed medical literature.

Prior authorization is required for prescriptions for all single-source histamine H2-receptor antagonists at all dose levels. Single source is defined as the brand-name drug or the innovator of a multiple-source drug. Payment for the single-source histamine H2-receptor antagonist will be authorized only for cases in which there is documentation of a previous trial and therapy failure with at least one multiple-source histamine H2-receptor antagonist.

Prior authorization is required for multiple-source histamine H2-receptor antagonists prescribed at full therapeutic dose levels for longer than a 90-day period or more frequently than one 90-day course of therapy per 12-month period per recipient. Payment for single- or multiple-source histamine H2-receptor antagonists at full therapeutic dose levels beyond the 90-day limit or more frequently than one 90-day course of therapy per patient per 12-month period will be authorized in cases where there is a diagnosis of:

1. Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas).
2. Symptomatic gastroesophageal reflux.
3. Symptomatic relapses of duodenal or gastric ulcers not responding to maintenance therapy and with documentation of either failure of Helicobacter pylori treatment or a negative Helicobacter pylori test result.
4. Barrett's esophagus.
5. Erosive esophagitis.

Other conditions will be considered on an individual patient basis with submitted documentation of medical necessity.

Prior authorization is required for proton pump inhibitor usage longer than 60 days or more frequently than one 60-day course per 12-month period. Payment for proton pump inhibitors beyond the 60-day limit or more frequently than one 60-day course per recipient per 12-month period shall be authorized upon request for those cases in which there is a diagnosis of:

1. Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas).
2. Barrett's esophagus.
3. Symptomatic gastroesophageal reflux after documentation of previous trials and therapy failure with at least one histamine H2-receptor antagonist at full therapeutic doses as defined by the histamine H2-receptor antagonist prior authorization guidelines.
4. Recurrent peptic ulcer disease after documentation of previous trials and therapy failure with at least one histamine H2-receptor antagonist at full therapeutic doses and with documentation of either failure of Helicobacter pylori treatment or a negative Helicobacter pylori test result.

Proton pump inhibitors prescribed concurrently with histamine H2-receptor antagonists shall be considered duplication of therapy. Payment for duplication of therapy will be considered on an individual basis after review of submitted documentation of medical necessity.

Prior authorization is not required for a cumulative 60 days of therapy with a proton pump inhibitor per 12-month period per recipient. The 12-month period is patient specific and begins 12 months prior to the requested date of prior authorization.

The medical condition of patients receiving continuous long-term treatment with proton pump inhibitors shall be reviewed yearly to determine the need for ongoing treatment.

Prior authorization is required for sucralfate at full therapeutic dose levels for longer than a 90-day period or more frequently than one 90-day course of therapy per patient per 12-month period. Payment for sucralfate at full therapeutic dose levels beyond the 90-day limit or more frequently than a 90-day course per patient per 12-month period will be authorized in cases where there is a diagnosis of:

1. Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas).
2. Symptomatic gastroesophageal reflux.
3. Symptomatic relapses of duodenal or gastric ulcers not responding to maintenance therapy and with documentation of either failure of Helicobacter pylori treatment or a negative Helicobacter pylori test result.
4. Barrett's esophagus.
5. Erosive esophagitis.

Other conditions will be considered on an individual basis with submitted documentation.

Concurrent sucralfate therapy prescribed with histamine H2-receptor antagonists or proton pump inhibitors beyond a 30-day period is considered duplication of therapy. Concurrent sucralfate therapy prescribed with misoprostol is also considered duplication of therapy. Payment for duplication of therapy will be considered on an individual patient basis after review of submitted documentation of medical necessity.

Prior authorization is not required for misoprostol when prescribed concurrently with a nonsteroidal anti-inflammatory drug. Prior authorization is required for any other therapy with misoprostol beyond 90 days. Justification for other therapy will be considered on an individual patient basis. Misoprostol prescribed concurrently with histamine H2-receptor antagonists, sucralfate, or proton pump inhibitors will be considered duplication of therapy. Payment for duplication of therapy will be considered on an individual patient basis after review of submitted documentation of medical necessity. (Cross-reference 78.28(1)"*d*"(1))

Prior authorization is required for single-source nonsteroidal anti-inflammatory drugs. Requests must document previous trials and therapy failure with at least two multiple-source nonsteroidal anti-inflammatory drugs. Prior authorization for chronic conditions will be issued for a 12-month period. Once a prior authorization has been issued, the single-source nonsteroidal anti-inflammatory drug being prescribed may be changed to another single-source product without a new request within the approved time period of 12 months. Patients who have been established on proven therapy with a single-source product prior to October 1, 1992, will not require a prior authorization.

Prior authorization is not required for prescriptions for multiple-source nonsteroidal anti-inflammatory drugs. (Cross-reference 78.28(1)"*d*"(2))

Prior authorization is required for single-source benzodiazepines. Requests must document a previous trial and therapy failure with one multiple-source product. Prior authorization will be approved for 12 months for documented:

1. Generalized anxiety disorder.
2. Panic attack with or without agoraphobia.
3. Seizure.
4. Nonprogressive motor disorder.
5. Bipolar depression.
6. Dystonia.

Prior authorization requests will be approved for a three-month period for all other diagnoses related to the use of benzodiazepines. Justification will be considered on an individual patient basis. Patients who have been established on proven therapy with a single-source product prior to October 1, 1992, will not require a prior authorization. (Cross-reference 78.28(1)*"d"*(3))

Prior authorization is required for therapy with growth hormones. All of the following criteria must be met for approval for prescribing of growth hormones:

1. Standard deviation of 2.0 or more below mean height for chronological age.
2. No intracranial lesion or tumor diagnosed by MRI.
3. Growth rate below five centimeters per year.
4. Failure of any two stimuli tests to raise the serum growth hormone level above seven nanograms per milliliter.
5. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males.
6. Epiphyses open.

Prior authorization will be granted for 12-month periods per recipient as needed. (Cross-reference 78.28(1)*"d"*(4))

Prior authorization is required for all prescription topical acne products for the treatment of mild to moderate acne vulgaris. An initial treatment failure of an over-the-counter benzoyl peroxide product, which is covered by the program, is required prior to the initiation of a prescription product, or evidence must be provided that use of these agents would be medically contraindicated. If the patient presents with a preponderance of comedonal acne, tretinoin products may be utilized as first line agents without prior authorization. (Cross-reference 78.28(1)*"d"*(5))

Prior authorization is required for all tretinoin prescription products for those patients over the age of 25 years. Alternatives such as topical benzoyl peroxide (OTC), and topical erythromycin, clindamycin, or oral tetracycline must first be tried (unless evidence is provided that use of these agents would be medically contraindicated) for the following conditions: endocrinopathy, mild to moderate acne (noninflammatory and inflammatory), and drug-induced acne. Prior authorization will not be required for those patients presenting with a preponderance of comedonal acne. Upon treatment failure with the above-mentioned products or if medically contraindicated, tretinoin products will be approved for three months. If tretinoin therapy is effective after the three-month period, approval will be granted for a one-year period. Skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive automatic approval for lifetime use of tretinoin products. (Cross-reference 78.28(1)*"d"*(6))

Prior authorization is required for single-source antihistamines including single active ingredient and combination products. Prior authorization is not required for multiple-source antihistamines. Single source is defined as the brand-name drug or the innovator of a multiple-source drug. Patients 21 years of age and older must have received two unsuccessful trials with other covered multiple-source antihistamines unless evidence is provided that the use of these agents would be medically contraindicated, prior to the utilization of single-source antihistamines. Patients 20 years of age and younger must have one unsuccessful trial with another covered multiple-source antihistamine unless evidence is provided that the use of these agents would be medically contraindicated, prior to the utilization of single-source antihistamines. (Cross-reference 78.28(1)*"d"*(7))

Prior authorization is required for all cephalexin hydrochloride monohydrate prescriptions. Treatment failure with cephalexin monohydrate will be required prior to the initiation of a cephalexin hydrochloride monohydrate prescription. (Cross-reference 78.28(1)*"d"*(9))

Prior authorization is required for erythropoietin prescribed for outpatients for the treatment of anemia. Patients who meet all of the following criteria may receive prior authorization for the use of erythropoietin:

1. Hematocrit less than 30 percent. If renewal of prior authorization is being requested, hematocrit over 36 percent will require dosage reduction or discontinuation. The fiscal agent may consider continuing therapy for higher hematocrit values on an individual basis after review of the evidence provided regarding need for continued therapy. Hematocrit laboratory values must be dated within six weeks of the prior authorization request.
2. Transferrin saturation greater than or equal to 20 percent (transferrin saturation is calculated by dividing serum iron by the total iron binding capacity), ferritin levels greater than or equal to 100 mg/ml, or on concurrent therapeutic iron therapy. Transferrin saturation or ferritin levels must be dated within three months of the prior authorization request.
3. For HIV-infected patients, the endogenous serum erythropoietin level must be less than or equal to 500 mU/ml to initiate therapy.
4. No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency. (Cross-reference 78.28(1)*"d"*(10))

Prior authorization is required for therapy with granulocyte colony stimulating factor. Laboratory values for complete blood and platelet count must be contained as directed by the manufacturer's instructions. The fiscal agent may require dose reduction and discontinuation of therapy based on the manufacturer's guidelines. Payment shall be authorized for one of the following uses:

1. Prevention or treatment of febrile neutropenia in patients with malignancies who are receiving myelosuppressive anticancer therapy.
2. Treatment of neutropenia in patients with malignancies undergoing myeloablative chemotherapy followed by bone marrow transplant.
3. Mobilization of progenitor cells into the peripheral blood stream for leukapheresis collection to be used after myeloablative chemotherapy.
4. Treatment of congenital, cyclic, or idiopathic neutropenia in symptomatic patients.

The fiscal agent may consider other uses on an individual basis after review of the evidence provided regarding the need for therapy with granulocyte colony stimulating factor. (Cross-reference 78.28(1)*"d"*(11))

Prior authorization is required for drugs used for the treatment of male sexual dysfunction. For prior authorization to be granted, the patient must:

1. Be 21 years of age or older.
2. Have a confirmed diagnosis of impotence of organic origin or psychosexual dysfunction.
3. Not be taking any medications which are contraindicated for concurrent use with the drug prescribed for treatment of male sexual dysfunction.

Approval for these drugs, with the exception of yohimbine, will be limited to four doses in a 30-day period.

The 72-hour emergency supply rule found below and at paragraph 78.28(1)*"d"* does not apply for drugs used for the treatment of male sexual dysfunction. (Cross-reference 78.28(1)*"d"*(13))

Prior authorization is required for ergotamine derivatives used for migraine headache treatment for quantities exceeding 18 unit doses of tablets, injections, or sprays per 30 days. Payment for ergotamine derivatives for migraine headache treatment beyond this limit will be considered on an individual basis after review of submitted documentation. For consideration, the following information must be supplied:

1. The diagnosis requiring therapy.
2. Documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications. (Cross-reference 78.28(1)*"d"*(14))

Prior authorization is required for narcotic agonist-antagonist nasal sprays for quantities exceeding 10 milliliters (approximately 60 doses) per 30 days. Payment for narcotic agonist-antagonist nasal spray beyond this limit will be considered on an individual basis after review of submitted documentation. For consideration, the diagnosis must be supplied. If the use is for the treatment of migraine headaches, documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications must be provided. (Cross-reference 78.28(1)*"d"*(15))

Prior authorization is required for isotretinoin therapy.

Payment will be approved for isotretinoin therapy for acne under the following conditions:

1. There are documented trials and therapy failures of systemic antibiotic therapy and topical tretinoin therapy. Documented trials and therapy failures of systemic antibiotic therapy and topical tretinoin therapy are not required for approval for treatment of acne conglobata.
2. There is a confirmed negative serum pregnancy test, if appropriate.
3. There is a plan for contraception in place, if appropriate.

Initial authorization will be granted for up to 20 weeks. A minimum of two months without therapy is required to consider subsequent authorizations.

Prior authorization of isotretinoin therapy for treatment of conditions other than acne will be considered on an individual basis after review of submitted documentation. (Cross-reference 78.28(1)*"d"*(16))

Prior authorization is required for oral antifungal therapy beyond a cumulative 90 days of therapy per 12-month period per patient. Payment for oral antifungal therapy beyond this limit will be authorized in cases where the patient has a diagnosis of an immunocompromised condition or a systemic fungal infection. Other conditions will be considered on an individual basis after review of submitted documentation. This prior authorization requirement does not apply to nystatin. (Cross-reference 78.28(1)*"d"*(17))

Prior authorization is required for nonparenteral vasopressin derivatives of posterior pituitary hormone products. Payment for nonparenteral vasopressin derivatives of posterior pituitary hormone products will be authorized for the following diagnoses:

1. Diabetes insipidus.
2. Hemophilia A.
3. Von Willebrand's disease.

Payment for nonparenteral vasopressin derivatives of posterior pituitary hormone products used in the treatment of primary nocturnal enuresis will be authorized for patients who are six years of age or older for periods of six months. Approvals will be granted for subsequent six-month periods only after a drug-free interval to assess the need for continued therapy. (Cross-reference 78.28(1)*"d"*(18))

Prior authorization is required for serotonin 5-HT1-receptor agonists for quantities exceeding 18 unit doses of tablets, syringes or sprays per 30 days. Payment for serotonin 5-HT1-receptor agonists beyond this limit will be considered on an individual basis after review of submitted documentation. For consideration, the following information must be supplied:

1. The diagnosis requiring therapy.
2. Documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications. (Cross-reference 78.28(1)*"d"*(19))

For all drugs requiring prior authorization, in the event of an emergency situation when a prior authorization request cannot be submitted and a response received within 24 hours such as after regular working hours or on weekends, a 72-hour supply of the drug may be dispensed and reimbursement will be made.

Prior authorization is required for selected brand-name drugs as determined by the department for which there is available an "A" rated bioequivalent generic product as determined by the federal Food and Drug Administration. For prior authorization to be considered, evidence of a treatment failure with the bioequivalent generic drug must be provided. A copy of a completed Med Watch form, FDA Form 3500, as submitted to the federal Food and Drug Administration shall be considered as evidence of a treatment failure. Brand-name drugs selected by the department shall be obtained from those recommended by the Iowa Medicaid drug utilization review commission after consultation with the state associations representing physicians. The list of selected brand-name drugs shall be published in the Medicaid Prescribed Drug Manual and the Physician Manual.

Prior authorization is required for lipase inhibitor drugs for weight loss. Requests must include documentation showing failure of other weight loss programs, a body mass index (BMI) equal to or greater than 30, one or more comorbidity conditions, and a weight management plan including diet and exercise. Prior authorization may be given for up to six months. Additional prior authorizations may be given on an individual basis after review of medical necessity and documented significant weight loss (at least 10 percent) from the individual's weight at the beginning of the previous prior authorization period. (Cross-reference 78.28(1)*"d"*(20))

Prior authorization is required for therapy with palivizumab. Payment for palivizumab shall be authorized for patients who meet one of the following criteria:

1. Patient is less than 24 months of age at start of therapy and has chronic lung disease requiring medication or oxygen within the last six months.
2. Patient is less than 12 months of age at start of therapy with a gestational age of less than or equal to 28 weeks.
3. Patient is less than 6 months of age at start of therapy with a gestational age between 28 weeks and 31 weeks.
4. Patient is less than 6 months of age at start of therapy with a gestational age of 32 weeks to 35 weeks and has at least one additional risk factor.

The fiscal agent will consider other conditions on an individual basis after review of submitted documentation. (Cross-reference 78.28(1)*"d"*(21))

b. Medical and sickroom supplies are payable when ordered by a legally qualified practitioner for a specific rather than incidental use. When a recipient 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 155.33, 155.34 and 204.308. For the purposes of the medical assistance program, prescriptions for medical supplies are required and shall be subject to the same provisions.

d. When it is not therapeutically contraindicated, the legally qualified practitioner shall prescribe a quantity of medication sufficient for a 30-day supply. Maintenance drugs in the following therapeutic classifications for use in prolonged therapy may be prescribed in 90-day quantities:

(1) Oral contraceptives
(2) Cardiac drugs
(3) Hypotensive agents
(4) Vasodilating agents
(5) Anticonvulsants
(6) Diuretics
(7) Anticoagulants
(8) Thyroid and antithyroid agents
(9) Antidiabetic agents

Prior authorization is not required for prescriptions for multiple-source nonsteroidal anti-inflammatory drugs.

(3) Prior authorization is required for single-source benzodiazepines. Requests must document a previous trial and therapy failure with one multiple-source product. Prior authorization will be approved for 12 months for documented:

1. Generalized anxiety disorder.
2. Panic attack with or without agoraphobia.
3. Seizure.
4. Nonprogressive motor disorder.
5. Bipolar depression.
6. Dystonia.

Prior authorization requests will be approved for a three-month period for all other diagnoses related to the use of benzodiazepines. Justification will be considered on an individual patient basis. Patients who have been established on proven therapy with a single-source product prior to October 1, 1992, will not require a prior authorization.

(4) Prior authorization is required for therapy with growth hormones. All of the following criteria must be met for approval for prescribing of growth hormones:

1. Standard deviation of 2.0 or more below mean height for chronological age.
2. No intracranial lesion or tumor diagnosed by MRI.
3. Growth rate below five centimeters per year.
4. Failure of any two stimuli tests to raise the serum growth hormone level above seven nanograms per milliliter.
5. Bone age 14 to 15 years or less in females and 15 to 16 years or less in males.
6. Epiphyses open.

Prior authorization will be granted for 12-month periods per recipient as needed. (Cross-reference 78.1(2)*"a"*(3))

(5) Prior authorization is required for all prescription topical acne products for the treatment of mild to moderate acne vulgaris. An initial treatment failure of an over-the-counter benzoyl peroxide product, which is covered by the program, is required prior to the initiation of a prescription product, or evidence must be provided that use of these agents would be medically contraindicated. If the patient presents with a preponderance of comedonal acne, tretinoin products may be utilized as first-line agents without prior authorization.

(6) Prior authorization is required for all tretinoin prescription products for those patients over the age of 25 years. Alternatives such as topical benzoyl peroxide (OTC), and topical erythromycin, clindamycin, or oral tetracycline must first be tried (unless evidence is provided that use of these agents would be medically contraindicated) for the following conditions: endocrinopathy, mild to moderate acne (noninflammatory and inflammatory), and drug-induced acne. Prior authorization will not be required for those patients presenting with a preponderance of comedonal acne. Upon treatment failure with the above-mentioned products or if medically contraindicated, tretinoin products will be approved for three months. If tretinoin therapy is effective after the three-month period, approval will be granted for a one-year period. Skin cancer, lamellar ichthyosis, and Darier's Disease diagnoses will receive automatic approval for lifetime use of tretinoin products.

(7) Prior authorization is required for single-source antihistamines including single active ingredient and combination products. Prior authorization is not required for multiple-source antihistamines. Single source is defined as the brand-name drug or the innovator of a multiple-source drug. Patients 21 years of age and older must have received two unsuccessful trials with other covered multiple-source antihistamines unless evidence is provided that the use of these agents would be medically contraindicated, prior to the utilization of single-source antihistamines. Patients 20 years of age and younger must have one unsuccessful trial with another covered multiple-source antihistamine unless evidence is provided that the use of these agents would be medically contraindicated, prior to the utilization of single-source antihistamines.

(8) Rescinded IAB 12/12/01, effective 2/1/02.

(9) Prior authorization is required for all cephalexin hydrochloride monohydrate prescriptions. Treatment failure with cephalexin monohydrate will be required prior to the initiation of a cephalexin hydrochloride monohydrate prescription.

(10) Prior authorization is required for erythropoietin prescribed for outpatients for the treatment of anemia. Patients who meet all of the following criteria may receive prior authorization for the use of erythropoietin:

1. Hematocrit less than 30 percent. If renewal of prior authorization is being requested, hematocrit over 36 percent will require dosage reduction or discontinuation. The fiscal agent may consider continuing therapy for higher hematocrit values on an individual basis after review of the evidence provided regarding the need for continuing therapy. Hematocrit laboratory values must be dated within six weeks of the prior authorization request.
2. Transferrin saturation greater than or equal to 20 percent (transferrin saturation is calculated by dividing serum iron by the total iron binding capacity), ferritin levels greater than or equal to 100 mg/ml, or on concurrent therapeutic iron therapy. Transferrin saturation or ferritin levels must be dated within three months of the prior authorization request.
3. For HIV-infected patients, the endogenous serum erythropoietin level must be less than or equal to 500 mU/ml to initiate therapy.
4. No evidence of untreated GI bleeding, hemolysis, or Vitamin B-12, iron or folate deficiency.

(11) Prior authorization is required for therapy with granulocyte colony stimulating factor. Laboratory values for complete blood and platelet count must be contained as directed by the manufacturer's instructions. The fiscal agent may require dose reduction and discontinuation of therapy based on the manufacturer's guidelines. Payment shall be authorized for one of the following uses:

1. Prevention or treatment of febrile neutropenia in patients with malignancies who are receiving myelosuppressive anticancer therapy.
2. Treatment of neutropenia in patients with malignancies undergoing myeloablative chemotherapy followed by bone marrow transplant.
3. Mobilization of progenitor cells into the peripheral blood stream for leukapheresis collection to be used after myeloablative chemotherapy.
4. Treatment of congenital, cyclic, or idiopathic neutropenia in symptomatic patients.

The fiscal agent may consider other uses on an individual basis after review of the evidence provided regarding the need for therapy with granulocyte colony stimulating factor.

(12) Prior authorization is required for selected brand-name drugs as determined by the department for which there is available an "A" rated bioequivalent generic product as determined by the federal Food and Drug Administration. For prior authorization to be considered, evidence of a treatment failure with the bioequivalent generic drug must be provided. A copy of a completed Med Watch form, FDA Form 3500, as submitted to the federal Food and Drug Administration shall be considered as evidence of a treatment failure. Brand-name drugs selected by the department shall be obtained from those recommended by the Iowa Medicaid drug utilization review commission after consultation with the state associations representing physicians. The list of selected brand-name drugs shall be published in the Medicaid Prescribed Drug Manual and the Physician Manual.

(13) Prior authorization is required for drugs used for the treatment of male sexual dysfunction. For prior authorization to be granted, the patient must:

1. Be 21 years of age or older.
2. Have a confirmed diagnosis of impotence of organic origin or psychosexual dysfunction.
3. Not be taking any medications which are contraindicated for concurrent use with the drug prescribed for treatment of male sexual dysfunction.

Approval for these drugs, with the exception of yohimbine, will be limited to four doses in a 30-day period.

The 72-hour emergency supply rule found above and at 78.1(2)"*a*"(3) does not apply for drugs used for the treatment of male sexual dysfunction. (Cross-reference 78.1(2)"*a*"(3))

(14) Prior authorization is required for ergotamine derivatives used for migraine headache treatment for quantities exceeding 18 unit doses of tablets, injections, or sprays per 30 days. Payment for ergotamine derivatives for migraine headache treatment beyond this limit will be considered on an individual basis after review of submitted documentation. For consideration, the following information must be supplied:

1. The diagnosis requiring therapy.
2. Documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications.

(15) Prior authorization is required for narcotic agonist-antagonist nasal sprays for quantities exceeding 10 milliliters (approximately 60 doses) per 30 days. Payment for narcotic agonist-antagonist nasal spray beyond this limit will be considered on an individual basis after review of submitted documentation. For consideration, the diagnosis must be supplied. If the use is for the treatment of migraine headaches, documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications must be provided.

(16) Prior authorization is required for isotretinoin therapy.

Payment will be approved for isotretinoin therapy for acne under the following conditions:

1. There are documented trials and therapy failures of systemic antibiotic therapy and topical tretinoin therapy. Documented trials and therapy failures are not required for approval for treatment of acne conglobata.
2. There is a confirmed negative serum pregnancy test, if appropriate.
3. There is a plan for contraception in place, if appropriate.

Initial authorization will be granted for up to 20 weeks. A minimum of two months without therapy is required to consider subsequent authorizations.

Prior authorization of isotretinoin therapy for treatment of conditions other than acne will be considered on an individual basis after review of submitted documentation.

(17) Prior authorization is required for oral antifungal therapy beyond a cumulative 90 days of therapy per 12-month period per patient. Payment for oral antifungal therapy beyond this limit will be authorized in cases where the patient has a diagnosis of an immunocompromised condition or a systemic fungal infection. Other conditions will be considered on an individual basis after review of submitted documentation. This prior authorization requirement does not apply to nystatin.

(18) Prior authorization is required for nonparenteral vasopressin derivatives of posterior pituitary hormone products. Payment for nonparenteral vasopressin derivatives of posterior pituitary hormone products will be authorized for the following diagnoses:

1. Diabetes insipidus.
2. Hemophilia A.
3. Von Willebrand's disease.

Payment for nonparenteral vasopressin derivatives of posterior pituitary hormone products used in the treatment of primary nocturnal enuresis will be authorized for patients who are six years of age or older for periods of six months. Approvals will be granted for subsequent six-month periods only after a drug-free interval to assess the need for continued therapy.

(19) Prior authorization is required for serotonin 5-HT1-receptor agonists for quantities exceeding 18 unit doses of tablets, syringes or sprays per 30 days. Payment for serotonin 5-HT1-receptor agonists beyond this limit will be considered on an individual basis after review of submitted documentation. For consideration, the following information must be supplied:

1. The diagnosis requiring therapy.
2. Documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications.

(20) Prior authorization is required for lipase inhibitor drugs for weight loss. Requests must include documentation showing failure of other weight loss programs, a body mass index (BMI) equal to or greater than 30, one or more comorbidity conditions, and a weight management plan including diet and exercise. Prior authorization may be given for up to six months. Additional prior authorizations may be given on an individual basis after review of medical necessity and documented significant weight loss (at least 10 percent) from the individual's weight at the beginning of the previous prior authorization period. (Cross-reference 78.1(2)"*a*"(3))

(21) Prior authorization is required for therapy with palivizumab. Payment for palivizumab shall be authorized for patients who meet one of the following criteria:

1. Patient is less than 24 months of age at start of therapy and has chronic lung disease requiring medication or oxygen within the last six months.
2. Patient is less than 12 months of age at start of therapy with a gestational age of less than or equal to 28 weeks.
3. Patient is less than 6 months of age at start of therapy with a gestational age between 28 weeks and 31 weeks.
4. Patient is less than 6 months of age at start of therapy with a gestational age of 32 weeks to 35 weeks and has at least one additional risk factor.

The fiscal agent will consider other conditions on an individual basis after review of submitted documentation.

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. Rescinded IAB 11/8/95, effective 1/1/96.

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79.11(1) Approval must be requested by the physician from the IFMC when the physician expects to perform a surgical procedure appearing on the department's preprocedure surgical review list published in the Medicaid providers' 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 providers' manual and instructions issued to providers by the IFMC.

79.11(2) The physician shall be issued a validation number for each request by the IFMC and advised if 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 IFMC does not give approval.

79.11(4) A denial letter will be issued by the IFMC to the patient, physician and facility when the requested procedure is not approved. The patient, physician or facility can request a reconsideration of the decision by filing a written request with the IFMC within 60 days of the date of the denial letter.

79.11(5) A denial letter of a request for reconsideration by the IFMC can be appealed by the aggrieved party to the department 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 forms. All providers of medical services interested in enrolling as Medicaid providers shall begin the enrollment process by contacting the fiscal agent at Provider Enrollment, CONSULTEC, Inc., P.O. Box 14422, Des Moines, Iowa 50306-3422, to request an application, with the following exceptions: nursing facility providers shall complete the process set forth in rule 441—81.13(249A) and intermediate care facilities for the mentally retarded shall complete the process set forth in rule 441—82.3(249A). CONSULTEC shall send the provider the appropriate application forms for completion as set forth below.

a. The following institutional providers shall complete the Institutional Medicaid Provider Enrollment, Form 470-2967:

(1) Ambulatory surgical centers.
(2) Home health agencies.
(3) Hospital and swing beds.
(4) Medicare-certified skilled facilities.
(5) Nursing facilities for the mentally ill.
(6) Psychiatric hospitals.
(7) Psychiatric medical institutions for children.
(8) Rehabilitation agencies. Rehabilitation agencies shall also complete Form 470-2971, Rehabilitation Agency Information Sheet.
(9) Inpatient and outpatient general hospitals. Inpatient and outpatient general hospitals shall also complete Form 2977, Supplemental Hospital Enrollment Form.

b. The following noninstitutional Medicaid providers shall complete the Noninstitutional Medicaid Provider Application, Form 470-2966:

(1) Ambulances.
(2) Area education agencies.
(3) Audiologists.
(4) Birth centers.
(5) Chiropractors.
(6) Clinics.
(7) Community mental health centers. Community mental health centers shall also complete Form 470-2970, Group Practice Information.
(8) Dentists.
(9) Durable medical equipment and supply dealers.

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441—93.106(239B) Orientation for PROMISE JOBS and the FIA. Every person who schedules and keeps an orientation appointment as described at subrule 93.105(2) shall receive orientation services.

93.106(1) *Requirements of orientation.* During orientation, each person shall receive a full explanation of the advantages of employment under the family investment program (FIP), services available under PROMISE JOBS, a review of participant rights and responsibilities under the FIA and PROMISE JOBS, a review of the LBP as described at 441—subrule 41.24(8), an explanation of the benefits of cooperation with the child support recovery unit, and an explanation of the other programs available through PROMISE JOBS, specifically the transitional Medicaid and child care assistance programs.

a. Each person shall sign Form WI-3305, Your Rights and Responsibilities, acknowledging that information described above has been provided.

b. Orientation participants are required to complete a current workforce development registration, Form 60-0330, Application for Job Placement and/or Job Insurance, when requested by PROMISE JOBS staff.

c. Orientation may also include completing self-assessment instruments.

d. The PROMISE JOBS worker shall meet with each orientation participant, or family if appropriate when two parents or children who are mandatory PROMISE JOBS participants are involved, to determine readiness to participate, establish expenses and a payment schedule and to discuss child care needs.

93.106(2) *Beginning PROMISE JOBS participation.* An individual becomes a PROMISE JOBS participant when that person attends the first day of the assessment component, as described at rule 441—93.111(239B), or provides the substitute assessment information as described at 93.111(1)*"a"*(4).

441—93.107(239B) Medical examinations. A person shall secure and provide written documentation signed by a licensed health practitioner, licensed in Iowa or adjoining states, to verify a claimed illness or disability within 45 days of a written request by staff.

441—93.108(239B) Self-initiated training. Registrants who have attended one or more days of training prior to participating in a PROMISE JOBS orientation are considered to be self-initiated. For registrants who at time of call-up for PROMISE JOBS orientation are in self-initiated classroom training, including government-sponsored training programs, PROMISE JOBS staff shall determine whether the training program meets acceptable criteria as prescribed for the classroom training component at rule 441—93.114(239B).

93.108(1) *Nonapprovable training.* When it is determined that the self-initiated training does not meet the criteria of rule 441—93.114(239B), the registrant has the option to participate in other PROMISE JOBS options or to use the nonapprovable training to meet the obligations of the FIA, under the other education and training component, as long as the training can still be reasonably expected to result in self-sufficiency. PROMISE JOBS expense allowances are not available for persons in nonapprovable training.

93.108(2) *Approvable training.* When a self-initiated training program meets PROMISE JOBS program standards, including SEID and ISHIP as described at 441—subrule 48.3(4), the participant shall be enrolled in the classroom training component in order to be eligible for child care and transportation assistance. Eligibility for payment of transportation and child care allowances shall begin for that month, or part thereof, in which the training plan is approved or the participant is removed from a waiting list as described at 93.105(3), whichever is later. Self-initiated participants are not eligible for expense allowances to pay for tuition, fees, books, or supplies.

441—93.109(239B) The family investment agreement (FIA). Families and individuals eligible for FIP shall, through any persons referred to PROMISE JOBS, enter into and carry out the activities of the FIA. Those who choose not to enter into the FIA or who choose not to continue its activities after signing the FIA shall enter into the limited benefit plan (LBP) as described at 441—subrule 41.24(8).

Those who choose not to enter into the FIA and who have filed Form 470-3826, Request for FIP Beyond 60 Months, shall be denied FIP as described at 441—paragraph 41.30(3)*"e."*

93.109(1) *FIA-responsible persons.*

a. All parents who are not exempt from PROMISE JOBS shall be responsible for signing and carrying out the activities of the FIA.

b. In addition, any other adults or a minor nonparental specified relative whose needs are included in the FIP grant shall be responsible for the FIA.

c. Persons who volunteer for PROMISE JOBS shall be responsible for the FIA as appropriate to their status as a parent or caretaker relative or child on the case.

d. When the FIP-eligible group holds a minor parent living with a parent or needy specified relative who receives FIP, as described at 441—paragraph 41.28(2)*"b"*(2), and both are referred to PROMISE JOBS, each parent or needy specified relative is responsible for a separate FIA.

e. When the FIP-eligible group holds a parent or parents or needy specified relative and a child or children who are all mandatory PROMISE JOBS participants, each parent or needy specified relative and each child would not have a separate FIA. All would be asked to sign one FIA with the family and to carry out the activities of that FIA. Copies of the FIA would be placed in individual case files.

f. When the FIP-eligible group holds a parent or parents or needy specified relative who is exempt from PROMISE JOBS and a child or children who are mandatory PROMISE JOBS participants, each child is responsible for completing a separate FIA.

93.109(2) *FIA requirements.* Except when developing the six-month FIA described at 441—paragraph 41.30(3)*"e,"* the FIA shall be developed during the orientation and assessment process through discussion between the FIP participants and PROMISE JOBS staff of coordinating PROMISE JOBS provider agencies, using Form 470-3095, Family Investment Agreement, and Form 470-3096, FIA Steps to Achieve Self-Sufficiency. The FIAs described at 441—paragraph 41.30(3)*"e"* may include orientation and assessment services.

a. The FIA shall require the FIA-responsible persons and family members who are referred to PROMISE JOBS to choose participation in one or more activities which are described below. The level of participation in one or more of the options shall be equivalent to the level of commitment required for full-time employment or shall be significant so as to move toward that level.

(1) The options of the FIA shall include, but are not limited to, all of the following: assessment, self-directed job search, job-seeking skills training, group and individual job search, high school completion activities, GED, ABE, ESL, postsecondary classroom training including entrepreneurial training, work experience, PROMISE JOBS on-the-job training, unpaid community service, parenting skills training, life skills training, monitored part-time or full-time employment, referral for family planning counseling, volunteer mentoring, and participation in FaDSS or other family development programs.

(2) The following are additional FIA options:

1. Participants have access to all services offered by the provider agencies.

2. Persons in work and training programs below a graduate degree which are funded outside of PROMISE JOBS and are approvable by PROMISE JOBS can use those as FIA options.

3. Persons in work and training programs below a graduate degree which are funded outside of PROMISE JOBS and are not approvable by PROMISE JOBS can use those as FIA options only when the participant is active in the nonapprovable program at the time of PROMISE JOBS orientation.

4. Work toward a graduate degree can be used as an FIA option only when the participant is active in the graduate program at the time of PROMISE JOBS orientation and the undergraduate degree was not earned under PROMISE JOBS.

(3) It is expected that employment shall be the principal activity of the FIA or shall be combined with other FIA options whenever it is possible for the participant to do so as part of the plan to achieve self-sufficiency.

(4) Participants who are placed on a waiting list, as described at 93.105(3), for a PROMISE JOBS component or supportive service shall include employment in the FIA unless family circumstances indicate that employment is not appropriate.

b. The FIA shall reflect, to the maximum extent possible, the goals of the family, subject to program rules, funding, the capability, experience and aptitudes of family members, and the potential market for the job skills currently possessed or to be developed.

(1) The FIA shall include the long-term goals of the family for achieving self-sufficiency and shall establish a time frame, with a specific ending date, during which the FIA family expects to become self-sufficient, after which FIP benefits will be terminated.

(2) The FIA shall outline the expectations of the PROMISE JOBS program and of the family, clearly establishing interim goals necessary to reach the long-term goals and self-sufficiency.

1. It shall identify barriers to participation so that the FIA may include a plan, appropriate referrals, and supportive services necessary to eliminate the barriers.

2. It shall stipulate specific services to be provided by the PROMISE JOBS program, including child care assistance, transportation assistance, family development services, and other supportive services.

(3) The FIA shall record participant response to the option of referral for family planning counseling. Participants who desire to do so may include family planning counseling in the steps of the FIA. It is not acceptable for the FIA to have family planning counseling as the only step of the FIA. Policies regarding family planning and the LBP are described at rule 441— 93.118(239B).

(4) Parents aged 19 and younger shall include parenting skills training as described at rule 441—93.116(239B) in the FIA.

(5) Unmarried parents aged 17 and younger who do not live with a parent or legal guardian, with good cause as described at 441—subrule 41.22(16), shall include FaDSS, as described at 441—Chapter 165, or other family development services, as described at rule 441—93.119(239B), in the FIA. The FaDSS or other family development services shall continue after the parent is aged 18 only when the participant and the family development worker believe that the services are needed for the family to reach self-sufficiency.

c. The FIA may incorporate a self-sufficiency plan which the family has developed with another agency or person, such as, but not limited to, Head Start, public housing authorities, child welfare workers, and FaDSS grantees, so long as that self-sufficiency plan meets the requirements of these rules and is deemed by PROMISE JOBS staff to be appropriate to the family circumstances. Participants shall authorize PROMISE JOBS to obtain the self-sufficiency plan and to arrange coordination with the manager of the self-sufficiency plan by signing Form MH-2201-0, Consent to Release or Obtain Information.

d. The FIA shall contain a provision for extension of the time frames and amendment of the FIA if funding for PROMISE JOBS components included in the FIA or required supportive services is not available.

e. The FIA shall be signed by the FIA-responsible person or persons and other family members who are referred to PROMISE JOBS, the PROMISE JOBS worker, and the project supervisor, before the FIA is considered to be completed.

f. If the FIA-responsible person demonstrates effort and is carrying out the steps of the FIA but is unable to achieve self-sufficiency within the time frame specified in the FIA, the FIA shall be renegotiated, the time frame shall be extended and the FIA shall be amended to describe the new plan for self-sufficiency.

g. Participants who choose not to cooperate in the renegotiation process shall be considered to have chosen the LBP.

h. Responsibility for carrying out the steps of the FIA ends at the point that FIP assistance is not provided to the participant.

i. When a participant who has signed an FIA loses FIP eligibility and the period the participant is without FIP assistance is one month or less and the participant has not become exempt from PROMISE JOBS at the time of FIP reapplication, the contents of the FIA and the participant's responsibility for carrying out the steps of that FIA shall be reinstated when FIP eligibility is reestablished.

The reinstated FIA shall be renegotiated and amended only if needed to accommodate changed family circumstances. Participants shall receive Form 470-3300, Your Family Investment Agreement Reminder, to remind them of their FIA obligation and to offer the opportunity to renegotiate and amend the reinstated FIA.

441—93.110(239B) Arranging for services. Staff is responsible for providing or helping the participant to arrange for employment-oriented services, as required, to facilitate the registrants' successful participation, including client assessment or case management, employment education, transportation, child care, referral for medical examination, and supportive services under the family development and self-sufficiency program described in 441—Chapter 165 or other family development programs, described in rule 441—93.119(239B). PROMISE JOBS funds shall be used to pay costs of obtaining a birth certificate when the birth certificate is needed in order for the registrant to complete the employment service registration process described in rule 441—93.106(239B). PROMISE JOBS funds may also be used to pay expenses for clients enrolled in Workforce Investment Act (WIA)-funded components when those expenses are allowable under these rules. Clients shall submit Form 470-0510, Estimate of Cost, to initiate allowances or change the amount of payment for expenses other than child care. Clients shall submit Form 470-2959, Child Care Certificate, to initiate child care payments or change the amount of child care payments. The caretaker, the provider and the worker shall sign Form 470-2959 before the provider is paid.

Payment for child care, if required for participation in any PROMISE JOBS component other than orientation, not specifically prohibited elsewhere in these rules, and not available from any other source, shall be provided for participants after service has been received as described at 441—Chapter 170.

441—93.111(239B) Assessment and assignment to other activities and components. PROMISE JOBS components and FIA options include assessment, job-seeking skills training, job search activities, monitored employment, basic education services, PROMISE JOBS OJT, work experience, unpaid community service, parenting skills training, life skills training, postsecondary classroom training including entrepreneurial training, volunteer mentoring, and FaDSS or other family development services.

93.111(1) *Assessment.* The purpose of assessment is to provide for a thorough self-evaluation by the FIP participant or family and to provide a basis for PROMISE JOBS staff to determine employability potential and to determine the services that will be needed to achieve self-sufficiency through PROMISE JOBS and the FIA. Assessment shall be conducted so as to ensure that participants can make well-informed choices and PROMISE JOBS workers can provide appropriate guidance as they complete the FIA to achieve the earliest possible self-sufficiency for the FIP family. Assessment services shall be provided through coordination among PROMISE JOBS provider agencies.

Assessment services shall be delivered through options known as assessment I, assessment II, and assessment III. These options may be provided as separate services, delivered at appropriate times during the duration of the FIA, or may be delivered as a continuous service up to the level necessary to provide the assessment needed for participant and PROMISE JOBS worker decisions while completing the FIA.

a. Assessment I shall be provided for all FIP participants. PROMISE JOBS staff shall meet individually with FIP recipients who are referred to PROMISE JOBS and who choose to develop the FIA. This assessment meeting, at a minimum, shall assess the family's financial situation, family profile and goals, employment background, educational background, housing needs, child care needs, transportation needs, health care needs, family-size assessment and participant wishes regarding referral to family planning counseling, and other barriers which may require referral to entities other than PROMISE JOBS for services.

(1) Assessment I may be the level of assessment appropriate for persons for whom: a part-time job has the potential to become full-time; there is an expectation of securing immediate employment; there are obvious literacy or other basic education barriers; family responsibilities limit the time that can be dedicated toward achieving self-sufficiency; there are transportation barriers; or there are multiple barriers which indicate that FaDSS, other family development services, or other social services are appropriate before other significant steps can be taken toward self-sufficiency.

(2) Persons in these circumstances may, based on the results of assessment I, complete the FIA to participate in activities such as, but not limited to, monitored part-time or full-time employment, job search, PROMISE JOBS OJT, unpaid community service, parenting skills training, referral for family planning counseling, FaDSS or other family development services, other social services, or basic or remedial education, perhaps in conjunction with other services.

(3) The services of assessment I shall be provided in one individual session unless the PROMISE JOBS worker documents a need for additional time.

(4) Participants shall have the option of substituting for assessment I assessment information which they have completed with another agency or person such as, but not limited to, WIA, Head Start, public housing authorities, child welfare workers, and family development services. Participants shall authorize PROMISE JOBS to obtain these assessment results by signing Form 470-0429, Consent to Release or Obtain Information. To be used in place of assessment I, the assessment results must contain all or nearly all of the items from paragraph *"a"* above and must have been completed within the past 12 months.

(5) Participants shall have the option to supplement assessment I with information in the manner as described in subparagraph (4) above and to establish communication between PROMISE JOBS staff and other agencies or persons in order to ensure that the family investment agreement activities do not conflict with any case plans which have already been established for the family. Authorizing this communication is not mandatory under the FIA but PROMISE JOBS staff shall have the authority to ask for verification of activities planned under another case plan when the participant reports conflicts.

b. Assessment II services shall be provided for those who, during assessment I, have no barriers to limit participation, have no specific career goal or plan, and need further assessment services to complete the FIA; and for those who are ready to advance to other components after completing a PROMISE JOBS activity or other services which were determined after assessment I and are part of the FIA.

(1) The services of assessment II may include, but are not limited to, literacy and aptitude testing, educational level and basic skills assessment, self-esteem building, interest assessment, exposure to nontraditional jobs, exposure to job-retention skills, goal setting, motivational exercises, exposure to job-seeking skills, and exposure to role models.

(2) Persons who complete assessment II may complete the FIA to participate in FIA activities such as, but not limited to, parenting skills training, referral for family counseling, job club or other job search activities, PROMISE JOBS OJT, work experience placement, or referral for entrepreneurial training.

(3) Assessment III services shall be provided for those who, during assessment I or II, request postsecondary classroom training as part of the FIA; or those whose previous participation indicates a need for and a likelihood of success in postsecondary classroom training.

c. Services of assessment III shall provide occupational specific assessment or guidance before completing the FIA for postsecondary classroom training. These services may be provided by PROMISE JOBS staff or other entities as arranged locally.

It is expected that assessment II and assessment III activities shall be provided in a maximum of 20 hours per week for each option unless the PROMISE JOBS worker documents a need for additional time.

d. FIP participants who previously participated in assessment options and then were canceled from FIP or entered an LBP may be required to participate in any assessment option again when the PROMISE JOBS worker determines that updated assessment is needed for development or amendment of the FIA.

e. Except for families who have filed Form 470-3826, Request for FIP Beyond 60 Months, family development and self-sufficiency (FaDSS) program participants attend orientation but are not referred to assessment until the FaDSS grantee approves the assignment of the FaDSS participant to other PROMISE JOBS activities. FaDSS participants who have completed assessment in the past may be required to complete assessment again when the FaDSS grantee approves assignment to other PROMISE JOBS activities if the PROMISE JOBS worker believes that extended assessment is necessary to reassess the participant's abilities and circumstances.

f. Except for assessment activities which occur on the same day as orientation, persons participating in assessment options are eligible for allowances for transportation and child care needed to allow the scheduled participation. Persons who miss any portion of scheduled assessment services may be required to make up the missed portion of the sessions, based on worker judgment and participant needs. When make-up sessions are required, the participant shall not receive an additional transportation allowance, but necessary child care shall be paid.

g. A participant who has completed assessment I and who wishes to include postsecondary classroom training in the FIA shall be required to participate in assessment II and assessment III unless the participant is not required to do so because:

(1) The person had been accepted for training by either SEID or an ISHIP training provider.

(2) The person is already involved in approvable self-initiated training at the time of PROMISE JOBS orientation.

These rules are intended to implement Iowa Code Supplement sections 239B.17 to 239B.22.

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CHAPTER 152
CONTRACTING
PREAMBLE

The rehabilitative treatment and supportive services contract will encompass rehabilitative and nonrehabilitative treatment services. Rehabilitative treatment and supportive services will include the following services: family-centered treatment, family preservation treatment, treatment family foster care, group care treatment, supportive services provided in family-centered and family foster care, and group care maintenance. Nonrehabilitative treatment services will include the following services: family-centered treatment and family preservation treatment.

Refer to 441—Chapter 185, Divisions II, III, IV, and V, for requirements for rehabilitative treatment services and 441—Chapters 156, 180, and 182 for requirements for supportive services.

DIVISION I
GENERAL PROVISIONS
PREAMBLE

This division sets forth the requirements for the content of the contract for rehabilitative treatment and supportive services and the conditions of participation. The term of the contract is limited to no more than two years.

441—152.1(234) Definitions.

"Agency" means any agency, public or private, which provides or represents itself as providing rehabilitative treatment or supportive services.

"Amount" means the number of units of a service core or level of care within a rehabilitative treatment service.

"Applicable services" means those services identified on the face sheet to be provided under the conditions of the contract.

"Certification" means the decision made by the department that the provider has met the applicable standards for rehabilitative treatment services.

"Child" means a person under 21 years of age.

"Client" means an individual or family group who has applied for and been found to be eligible for rehabilitative treatment or supportive services from the Iowa department of human services.

"Contract" means formal written agreement between the Iowa department of human services and a provider of rehabilitative treatment or supportive services.

"Department" means the Iowa department of human services.

"Duration" means the maximum period of time for which the service core or level of care within a rehabilitative treatment service is authorized.

"Family" includes the following members:

1. Legal spouses (including common law) who reside in the same household.
2. Natural, adoptive or step mother or father, and children who reside in the same household.
3. A child who lives alone or who resides with a person, or persons, not legally responsible for the child's support.

"Grant" means an award of funds to develop specific programs or achieve specific outcomes.

"Juvenile court officer" means a person appointed as a juvenile court officer under Iowa Code chapter 602 and a chief juvenile court officer appointed under Iowa Code chapter 602.

"Nonrehabilitative treatment services," for the purpose of this chapter, means rehabilitative services designed to address a child's nonrehabilitative treatment needs as defined in rule 441—185.1(234) in one of the following programs:

1. Family-centered program.
2. Family preservation program.

"Project manager" means a department employee who is assigned to assist in developing, monitoring and evaluating a contract and to provide related technical assistance.

"Provider" means any natural person, company, firm, association, or other legal entity under contract with the department pursuant to this chapter.

"Purchase of service system" means the system within the department for contracting and payment for services.

"Referral worker" means the department worker or juvenile court officer who refers the case to the review organization and who is responsible for carrying out the follow-up activities after the review organization service necessity determination and service authorization process is completed.

"Rehabilitative treatment services," for the purpose of this chapter, means services designed to address the rehabilitative treatment needs of a child in one of the following programs:

1. Family-centered program.
2. Family preservation program.
3. Family foster care.
4. Group care program.

"Review organization" means the entity designated by the department to make rehabilitative treatment service authorization determination.

"Scope" means the rehabilitative treatment service selected and the service core or level of care within the program that is selected.

"Service authorization" means the process of service necessity determination and service authorization of scope, amount and duration by the review organization.

"Service core" means a set of rehabilitative treatment services delivered to an individual or family that addresses the needs of the individual or family as set forth in the treatment plan.

"Social services" means a set of actions purposefully directed toward human needs which are identified as requiring assistance from others for their resolution.

"Supportive services" for purposes of contracting and financial and statistical reports means family-centered supportive services as defined in rule 441—182.1(234), supervision and home studies provided in family foster care and group care maintenance as defined in rule 441—156.1(234).

"Unit of service" means a specified quantity of service.

441—152.2(234) Conditions of participation relevant to all contracts.

152.2(1) *Service descriptions.* The provider shall comply with the requirements for applicable services as described in the appendix to the contract.

152.2(2) *Signed contract.* A contract can be effective only when signed by all parties required in subrule 152.22(4).

152.2(3) *Provider certification.* The provider shall be certified to provide the applicable rehabilitative treatment services before the contract can be effective. Out-of-state providers shall meet Iowa certification requirements.

152.2(4) *Civil rights laws.* The provider shall be in compliance with all state civil rights laws and regulations and with all applicable federal civil rights laws and regulations with respect to equal employment opportunity.

152.2(5) *Title VI compliance.* The provider shall be in compliance with Title VI of the 1964 Civil Rights Act and all other federal, state, and local laws and regulations regarding the provision of services.

152.2(6) *Section 504 compliance.* The provider shall be in compliance with Section 504 of the Rehabilitation Act of 1973 and with all federal, state, and local Section 504 laws and regulations.

152.2(7) *Americans with Disabilities Act compliance.* The provider shall be in compliance with the Americans with Disabilities Act of 1990 and with all federal, state and local laws and regulations regarding the Americans with Disabilities Act.

152.2(8) *Affirmative action.* The provider shall apply affirmative action measures appropriate to correct deficiencies or to overcome the effects of past or present practices, policies, or other barriers to equal employment opportunity.

152.2(9) *Equal opportunity.* The provider shall exclude no person from the participation in or receipt of programs, activities or benefits on the grounds of race, color, creed, national origin, sex, age, religion, political belief, or physical or mental disability. Nor shall the provider discriminate against any person in employment or applying for employment on the grounds of race, color, creed, national origin, sex, age, religion, political belief, or physical or mental disability.

152.2(10) *Nondiscrimination.* The provider shall carry out all activities under the terms of any rehabilitative treatment and supportive services contract in a manner that does not discriminate against any person because of the person's race, color, creed, national origin, sex, age, religion, political belief, or physical or mental disability.

152.2(11) *Abuse reporting.* The provider shall have written policy and procedure that complies with applicable state and local laws for the reporting of child abuse.

152.2(12) *Confidentiality.* The provider shall comply with all applicable federal and state laws and regulations on confidentiality including rules on confidentiality contained in 441—Chapter 9. The provider shall have a written policy and procedure for maintaining individual client confidentiality, including client record destruction.

152.2(13) *Client appeals and grievances.* The provider shall have a written policy and procedure for handling client appeals and grievances, and shall provide information to clients about their rights to appeal.

152.2(14) *Financial and statistical records.* The provider shall maintain sufficient financial and statistical records, including program and census data, to document the validity of the reports submitted to the department. (See 441—subrule 185.102(3).)

a. The records shall be available for review at any time during normal business hours by department personnel, the purchase of rehabilitative treatment and supportive services fiscal consultant, and state or federal audit personnel.

b. These records shall be retained for a period of five years after final payment.

152.2(15) *Reports on financial and statistical records.* Financial and statistical reports shall be submitted as required in rules 441—185.102(234) and 441—185.103(234). Failure to do so within the required time limits is grounds for termination of the contract. This subrule is held in abeyance for purposes of establishing rates effective during the time period beginning July 1, 1996, through June 30, 1998.

152.2(16) *Maintenance of client records.* Records for clients served through a Rehabilitative Treatment and Supportive Services Contract, Form 470-3052, shall be retained by the provider for a period of five years after service to the client terminates. Client records for rehabilitative treatment and supportive services shall comply with the requirements set forth at 441—subrule 185.10(6) and, as applicable, 441—subrule 156.7(2) and 441—subrule 182.5(5).

152.2(17) *Provider charges.* A provider shall not charge departmental clients more than it receives for the same rehabilitative treatment and supportive services provided to nondepartmental clients.

152.2(18) *Special purpose organizations.* A provider may establish a separate, special-purpose organization to conduct certain of the provider's client-related or non-client-related activities. For example, a development foundation assumes the provider's fund-raising activity. Often, the provider does not own the special-purpose organization (e.g., a nonprofit, non-stock-issuing corporation), and has no common governing body membership. A separate special-purpose organization shall be considered to be a related party for purposes of 441—subrule 185.105(11) when one of the following applies:

a. The provider controls the organization through contracts or other legal documents that give the provider the authority to direct the organization's activities, management, and policies.

b. The provider is, for all practical purposes, the primary beneficiary of the organization's activities. The provider should be considered the special-purpose organization's primary beneficiary if one or more of the following circumstances exist:

(1) The organization has solicited funds on the provider's behalf with provider approval and substantially all funds so solicited were contributed with the intent of benefiting the provider.

(2) The provider has transferred some of its resources to the organization, substantially all of whose resources are held for the benefit of the provider.

(3) The provider has assigned certain of its functions to a special-purpose organization that is operating primarily for the benefit of the provider.

152.2(19) *Certification by department of transportation.* Each service provider of public transit services shall submit Form 020107, Certification Application for Coordination of Public Transit Services, and a copy of "Certificate of Insurance" (an ACORD form or similar or self-insurance documentation) to the applicable regional office annually showing information regarding compliance with or exemption from public transit coordination requirements as found in Iowa Code chapter 324A and department of transportation rules 761—Chapter 910.

Failure to cooperate in obtaining or providing the required documentation of compliance or exemption is grounds for denial or termination of the contract.

152.2(20) *Services provided.* Services provided, as described on Form 470-3051, Rehabilitative Treatment and Supportive Services Contract Face Sheet, and appendices, shall at a minimum meet the rules found in the Iowa Administrative Code for a particular rehabilitative treatment or supportive service or the contract may be terminated.

152.2(21) *Indemnity and insurance clauses.*

a. The provider agrees that it will indemnify, hold harmless and defend the state, the department, and its officers and employees from and against all suits, actions, or claims for personal injury or death, or damage to property because of any act, omission or neglect of the provider, its officers, agents or employees in the provision of care or services as provided for by administrative rule and this contract, including, but not limited to:

(1) Personal injury, death or property damage of a client receiving care or services, or while on a premises owned, leased or operated by the provider, or while being transported by the provider, either directly or by arrangement.

(2) Personal injury, death or property damage of another caused by a client while receiving care or service from the provider.

This provision does not create any right or cause of action in the public or a third party to bring a claim or suit under or pursuant to its terms.

b. The provider agrees that it shall have in force and effect a liability insurance policy covering all its operations in providing the care and services required by the administrative rules and by contract, including the indemnity provision above. A "Certificate of Insurance" identifying the insurance company, the policy period, the type of policy and the limits of coverage shall be filed with the department. The insurance policy and the certificate of insurance shall show the state of Iowa and the department of human services as additional insureds. The provider further agrees that anyone transporting, or authorized to transport, clients in privately owned vehicles shall have liability insurance in force and effect covering any claim which may arise from this transport.

152.2(22) *Renegotiation clause.* In the event there is a revision of federal or state laws or regulations and this contract no longer conforms to those laws or regulations, both parties will review the contract and renegotiate those items necessary to conform with the new federal or state laws or regulations.

152.2(23) *Subcontracting or assignability.* The provider shall have no right to assign the contract. When a provider of services pursuant to this chapter delivers service through a subcontract, the provider is responsible for the subcontractor's meeting the requirements found in this division. A copy of all subcontracts for any rehabilitative treatment or supportive services, as described in the contract, or any changes to that subcontract shall be provided to the project manager at least one month prior to implementation of the subcontract. The department shall have the right to reject all or part of the subcontract. All subcontractors shall meet these requirements:

a. All conditions of the contract shall be incorporated into any subcontract.

b. All subcontractors shall meet certification requirements for rehabilitative treatment services.

c. All subcontractors shall meet requirements for supportive services.

d. A subcontract or other written agreement will not relieve the provider of responsibility or accountability to the department for the conditions of the contract.

e. The provider has the responsibility for billing for the service and for reimbursing the subcontractor. However, the provider shall not bill for rehabilitative treatment and supportive services provided by the subcontractor unless a copy of the subcontract or any changes to the subcontract has been submitted to the project manager as required. When a subcontract or a portion of a subcontract has been rejected by the department, the provider shall not bill for services provided totally or in part through that rejected subcontract or through the part of a subcontract which was rejected. The department shall not be liable for payment for services provided through a subcontract or that portion of a subcontract which has been rejected.

f. The costs of all subcontracted services are subject to the requirements and limits set forth in rules 441—185.101(234) to 441—185.108(234). This paragraph is held in abeyance for purposes of establishing rates effective during the time period beginning July 1, 1996, through June 30, 1998.

152.2(24) *Nonemployment.* The provider shall be an independent contractor in the performance of contract obligations under Iowa Code chapter 669. There is no duty created for the department to defend or indemnify the provider.

152.2(25) *Across-the-board cuts.* Payment under the contract may be subject to across-the-board cuts pursuant to Iowa Code section 8.31.

152.2(26) *Monitoring equal opportunity and affirmative action compliance.*

a. Providers shall submit to the project manager the following forms at the time of submission of the initial contract for monitoring of compliance with the requirements set forth at 152.2(4), 152.2(5), 152.2(6) and 152.2(8): Equal Opportunity Review, Form 470-0148, and, as applicable, Accessibility Checklist, Form 470-0149, and Section 504 Transition Plan: Structural Accessibility, Form 470-0150. The Desk Audit for Title VI and Section 504 Compliance, Form 470-2215, shall be submitted to the project manager annually thereafter. The project manager shall submit the required forms to the department.

b. The bureau of equal opportunity shall review the forms. If the bureau finds areas of noncompliance, the bureau shall notify the provider. The provider shall develop a plan of corrective action addressing each area of noncompliance. The corrective action plan shall include timelines for implementation and shall be submitted to the department for approval.

c. Failure to develop and implement an acceptable plan of corrective action within the timelines specified in the plan shall be grounds for termination of the contract.

152.2(27) *Age Discrimination Act compliance.* The provider shall be in compliance with the Age Discrimination Act of 1975 and with all federal, state, and local laws and regulations regarding the Age Discrimination Act.

441—152.3(234) Appeals of departmental actions. Departmental actions other than rate determinations may be appealed pursuant to 441—Chapter 7. Requests for review of rate determinations may be submitted in writing to the chief of the bureau of purchased services. The request shall explain the rates in question and the reasons for dissatisfaction. The chief of the bureau of purchased services shall respond to the request in writing or request additional information within ten working days.

441—152.4(234) Review of financial and statistical reports. Authorized representatives of the department or state or federal audit personnel shall have the right to review the general financial records of a provider. The purpose of the review is to determine if expenses reported to the department have been handled as required under rule 441—185.102(234). Representatives shall provide proper identification and shall use generally accepted auditing principles. The review may include an on-site visit to the provider, the provider's central accounting office, the offices of the provider's agents, a combination of these, or, by mutual decision, to other locations.

441—152.5(234) Copyright and patents. The activities and results of contract activity may be published subject to confidentiality requirements. The provider shall furnish a copy of the published material free of charge to the department within ten days of publication.

The department reserves the right to use and duplicate the publication for internal state purposes. In no event shall the department be charged for the use of the copyrighted materials.

441—152.6(234) Drug-free workplace. The provider shall operate a drug-free workplace in accordance with Executive Order Number 38, published in the Iowa Administrative Bulletin April 19, 1989, and rule 581—19.5(19A).

441—152.23(234) Contract administration.

152.23(1) *Contract management.* During the contract period, the assigned project manager designated in the contract shall be the contract liaison between the department and the provider. The project manager shall be contacted on all interpretations and problems relating to the contract and shall follow the issues through to their resolution. The project manager shall also monitor performance under the contract and shall provide or arrange for technical assistance to improve the provider's performance if needed. Report of On-Site Visit, Form 470-0670, shall be used to monitor performance under the contract. The project manager shall make at least one on-site visit to each provider of rehabilitative treatment or supportive services during the term of the contract. The on-site visit shall be coordinated with on-site visits scheduled to fulfill requirements for provider audit, licensing, and certification or other on-site visits required by the department. Site visits to out-of-state providers shall be made at the discretion of the region responsible for administration of the contract.

152.23(2) *Contract amendment.*

a. The contract shall be amended only upon agreement of both parties except as provided for in paragraphs 152.23(2)*"b," "c,"* and *"d."* Amendment of the Rehabilitative Treatment and Supportive Services Contract, Form 470-3053, shall be completed by the provider to amend the services being provided, unless the amendment is being processed with a contract renewal. If the amendment is being processed with a contract renewal, the amendment can be indicated on the contract face sheet as a "contract renewal and amendment" and Form 470-3053 does not need to be submitted, as the signature page of the contract renewal can serve as the approval mechanism with authorized signatures. A written explanation of the nature of the amendment shall be attached. Amendments to add a new service must meet the requirements of any licensing or certification required as indicated by issuance of a current certificate of approval. Effective January 1, 1998, the department shall only approve amendments to add a service to an existing contract for which a negotiated rate has been established.

b. Effective August 1, 1998, a contract may be unilaterally amended by the department to delete an existing service if agreement upon a negotiated rate is not reached in accordance with rule 441—185.112(234), except as provided for at 441—subrule 185.112(12). The department shall give the provider 30 days' notice of its intent to amend the rehabilitative treatment and supportive services contract between the provider and the department.

c. A contract may be unilaterally amended by the department to delete an existing service if certification or a required license for that service is revoked, denied or has been voluntarily withdrawn by the provider. The department shall give the provider ten days' notice of its intent to amend the rehabilitative treatment and supportive services contract between the provider and the department.

152.23(3) *Contract renewal.* A joint decision to pursue renewal of the contract shall be made at least 60 days prior to the expiration date. Each contract renewal requires one on-site visit by the project manager and documentation of an evaluation process through the use of Form 470-3054, Contract Renewal Evaluation Guide. The evaluation shall also include the use of other evaluation tools specified in the contract. The results of the evaluation shall be taken into consideration in the department's decision to renew the contract. Site visits to out-of-state providers shall be made at the discretion of the region responsible for administration of the contract.

152.23(4) *Contract termination.*

a. The department may terminate the contract upon ten days' notice for cause except in the event of revocation of licensure, certification or imminent danger to clients, in which case the contract shall be terminated immediately upon notice. The provider or the department may terminate this contract without cause upon 30 days' notice. Notice of termination shall be provided by certified mail.

b. Causes for termination during the period of the contract are:

(1) Determination by the department that insufficient funds are available to continue the services involved.

(2) Failure of the provider to complete or submit required reports.

(3) Failure of the provider to make financial and statistical records available for review by the department or authorized party.

(4) Failure of either party to abide by the provisions of the contract.

(5) Failure to reach agreement on negotiated rates within 130 days of initiating rate negotiations in accordance with rule 441—185.112(234).

c. Within 20 days of any termination made under this clause, the provider shall supply the department with financial statements detailing all costs up to the effective date of termination. The sole and complete remedy of the provider shall be payment for services completed prior to the effective date of termination.

441—152.24(234) Client eligibility and referral.

152.24(1) *Determination of eligibility.* For the department to make payment for rehabilitative treatment services, clients shall be determined eligible by the review organization. Eligibility for nonrehabilitative treatment services shall be determined pursuant to 441—subrule 185.2(4). Eligibility for supportive services shall be determined by the referral worker pursuant to the rules established for the service. The department shall not make payment for rehabilitative treatment or supportive services provided prior to the client's eligibility determination.

152.24(2) *Court order.* If a child and family have been referred to the review organization and the review organization has not authorized rehabilitative treatment services, but the services have been ordered by the juvenile court, the referral worker shall refer the case back to the review organization for reconsideration of eligibility in light of the juvenile court's determination. If the review organization continues not to authorize the services ordered by the juvenile court, the department shall make payment subject to availability of authorized funds.

441—152.25(234) Amount, scope, and duration of services. Any change in the scope, or increase in the amount or duration of rehabilitative treatment services, shall be authorized by the review organization.

441—152.26(234) Client fees. The provider shall agree not to require any fee from departmental clients unless a fee is required by the department and is consistent with federal regulation and state policy.

These rules are intended to implement Iowa Code section 234.6.

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441—153.57(234) Program administration.

153.57(1) *Provider responsibilities.*

a. For a member whose case is being overseen by the department's service worker, in providing services to the member, the provider shall follow the department's case plan and shall submit quarterly reports on the member's progress to the department's service worker assigned responsibility for the case as required by 441—subparagraph 150.3(3)"*j*"(2).

b. For a member whose case is being overseen by the department's service worker and the Iowa Plan contractor, the provider shall follow the case plan designated by the Iowa Plan and shall submit reports as required by the Iowa Plan.

c. For a member whose case is being overseen by the department's service worker and a county central point of coordination, the provider shall follow the central point of coordination's case plan and shall submit quarterly reports on the member's progress to the department's service worker and central point of coordination as required by 441—subparagraph 150.3(3)"*j*"(2).

d. Providers furnishing services to members who are residents of a county without an approved county management plan shall furnish services in accordance with the provisions of the last approved county management plan, federal and state statutes and regulations, the department rules governing the mental illness, mental retardation and developmental disabilities local services being provided, and the rules of this chapter.

e. Providers furnishing services to members whose cases are being overseen by the department's service worker and the Iowa Plan contractor shall furnish services in accordance with the needs of the member and federal and state statutes and regulations and department rules and Iowa Plan criteria. The Iowa Plan contractor's denial of payment for a service which is a state responsibility shall not create a payment responsibility for the county.

f. Providers shall cooperate in furnishing the Iowa Plan contractor with any information the provider has that is necessary to determine the initial or continued need for service for a person for whom funding is sought through the Iowa Plan.

g. Providers shall cooperate in providing the department with any information the provider has that is necessary to determine the initial or continued eligibility of a person for whom funding is sought. Providers shall notify the department within 30 days of any change in a member's circumstances that would affect the member's eligibility or the member's cost of services.

h. Providers shall maintain in good standing all certifications, accreditation, licensure, or other applicable federal and state statutory and regulatory requirements; comply with all applicable federal and state confidentiality laws and applicable rules in the Iowa Administrative Code; and comply with all applicable federal and state requirements with respect to civil rights, equal employment opportunity, and affirmative action.

i. Providers shall notify the division administrator within 24 hours of any change in licensure, certification, accreditation, or other applicable statutory or regulatory standing. Providers shall maintain, for a period of five years from the date of service, clinical and financial records adequate to support the need for and provision of the services purchased by the department. The department or its authorized agent shall have access to these records to perform any clinical or fiscal audits the department deems necessary.

j. Providers shall comply with the rules of this chapter.

k. Providers under investigation by any federal or state statutory or regulatory authority may be prohibited from accepting for service any new applicants or members whom the providers did not already serve on the date the investigation was initiated. For the duration of the investigation, the provider shall not be prohibited from serving and receiving payment for services provided to members whom the provider served on the date the investigation was initiated.

l. Providers with a special mental health-mental retardation county contract agreement may terminate the agreement for any reason by giving 30 days' notice to the department and state payment program members they serve and making arrangements for the continuity of care of any state payment program member who would be affected by the termination.

153.57(2) *Department responsibilities.* The department as sponsoring agency shall be responsible for all contacts with governmental units as necessary, with in-state and out-of-state agencies as necessary, with the applicant or member's family and others in matters concerning the applicant or member's legal settlement and residency, entitlements from other sources and eligibility for the state payment program.

The department shall verify with the county central point of coordination the services and unit rates of providers applying for a special mental health-mental retardation county contract agreement by Form 470-3336.

The department reserves the right to terminate special mental health-mental retardation county contract agreements established via Form 470-3336 for any reason by giving 30 days' notice to the provider and to state payment program members the provider serves and making arrangements for the continuity of care of any state payment program member who would be affected by the termination. Failure by a provider to abide by the rules of this chapter may be cause for termination. Citations or sanctions against the provider by any federal or state statutory or regulatory authority may be cause for termination.

The department reserves the right not to enter into a special mental health-mental retardation county contract agreement with a provider who has been cited or sanctioned by a federal or state statutory or regulatory authority within two years of the provider's application for a special mental health-mental retardation county contract agreement via Form 470-3336, or who has failed to demonstrate that the provider meets the requirements for a special mental health-mental retardation county contract agreement as stated in this chapter.

153.57(3) *Payment to providers.* The following policies shall govern payment to providers for services furnished to members:

a. Payment for service shall be made in accordance with 441—Chapter 150 and departmental procedures. Form 470-0020, Purchase of Service Provider Invoice, shall be used to bill for services covered by a purchase of service contract or a special mental health-mental retardation county contract agreement for services actually provided to a member from the effective date of state payment program eligibility.

Payment for services which are the responsibility of the Iowa Plan contractor shall be made in accordance with the Iowa Plan's procedures and shall be submitted to the Iowa Plan contractor on Form 470-0020, Purchase of Service Provider Invoice, for payment.

Form 07-350, Purchase Order/Payment Voucher, shall be used for all other services.

b. Payment to a provider with a special mental health, mental retardation county contract agreement for services provided to a member shall be the purchase of service rate less 4.3 percent or, if there is no purchase of service contract, the unit rate paid on November 1, 2001, by the county in which the provider is located, less 4.3 percent. Payment to a provider for services to a member whose case is being overseen by the department's service worker and the Iowa Plan shall be at the rate established by the Iowa Plan contractor as of November 1, 2001, less 4.3 percent.

Payment to a provider requesting enrollment in a special mental health, mental retardation county contract agreement subsequent to December 1, 2001, shall be at the rate paid on November 1, 2001, by the county in which the provider is located, less 4.3 percent. Payment to a provider requesting enrollment in the Iowa Plan subsequent to December 1, 2001, shall be at the rate in effect on November 1, 2001, less 4.3 percent.

c. Rescinded IAB 7/2/97, effective 7/1/97.

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CHAPTER 154
Rescinded IAB 9/6/89, effective 11/1/89
[See 441—Chapter 168]

51.38(4) *Long-term care service equipment and supplies.* The equipment and supplies required for the hospital's long-term care service shall be the same as required by Iowa Code chapter 135C and the rules promulgated under its authority for the category of health care facility involved.

51.38(5) *Long-term care service space.* The space requirements for the various areas and resident rooms of the hospital's long-term care service shall be the same as required by Iowa Code chapter 135C and the rules promulgated under its authority for the category of health care facility involved.

481—51.39(135B) Penalty and enforcement. See Iowa Code sections 135B.14 to 135B.16.

481—51.40(135B) Validity of rules. If any provision of these rules or the application thereof to any person or circumstances shall be held invalid, such validity shall not affect the provisions or application of these rules which can be given effect without the invalid provision or application, and to this end the provisions of these rules are declared to be severable.

481—51.41 to **51.49** Reserved.

481—51.50(135B) Minimum standards for construction after January 26, 1994, and prior to July 8, 1998. Hospitals and off-site premises licensed under this chapter shall be built in accordance with these construction requirements. These rules apply to plans approved by the state fire marshal or local authority having jurisdiction after January 26, 1994, and prior to July 8, 1998, for new construction, renovations, additions, functional alterations, or changes in utilization to existing facilities.

51.50(1) *Variances.* Certain patient populations, conditions in the area, or the site may justify variances. In specific cases, variances to the rules may be granted by the director of the Iowa department of inspections and appeals after the following conditions are met:

a. The design and planning for the specific property shall offer improved or compensating features which provide equivalent desirability and utility;

b. Alternate or special construction methods, techniques, and mechanical equipment shall offer equivalent durability, utility, safety, structural strength and rigidity, sanitation, odor control, protection from corrosion, decay and insect attack, and quality of workmanship;

c. The health, safety or welfare of any patient shall not be endangered;

d. Variations are limited to the specific project under consideration and shall not be construed as establishing a precedent for similar acceptance in other cases;

e. Occupancy and function of the building shall be considered; and

f. Type of licensing shall be considered.

51.50(2) *General requirements.* Hospitals shall comply with the following guidelines and codes in the development of their building plans and construction of their facilities:

a. "Guidelines for Construction and Equipment of Hospital and Medical Facilities," 1992-93 edition, The American Institute of Architects Committee on Architecture for Health.

b. "The Model Energy Code," 1989 edition, Council of American Building Officials.

c. Special design considerations for persons with disabilities (patients, staff, and visitors) American National Standards Institute No. A117.1 and the Americans With Disabilities Act, Titles II and III.

d. State Building Code, 1991 edition.

51.50(3) *Life safety.* Facilities and construction shall be in accordance with National Fire Protection Association (NFPA) Standard 99 (Standards for Health Care Facilities—1993 edition), Standard 101 (Life Safety Code — 1985 edition), and rules of local authorities. Facilities and construction shall be approved by the state fire marshal or local authority having jurisdiction.

51.50(4) *Elevator requirements.*

a. All facilities where either resident beds or other facilities for patients are not located on the first floor shall have electric or electrohydraulic elevators. The first floor is the floor first reached from the main front entrance.

b. Elevators shall comply with division of labor services rules as promulgated under Iowa Code chapter 89A and 875 IAC Chapters 71 to 77.

51.50(5) *Plumbing requirements.* All plumbing and other pipe systems shall be designed and installed in accordance with the requirements of the Iowa State Plumbing Code, 1991 edition, and applicable provisions of local ordinances.

51.50(6) *Mechanical requirements.* Pressure vessels, steam and hot water heating and domestic water heating systems shall comply with division of labor services rules promulgated under Iowa Code chapter 89 and 875 IAC Chapters 200 to 209.

51.50(7) *Electrical requirements.* All electrical and electronic systems shall comply with NFPA Standard 70 National Electrical Code, 1993 edition.

51.50(8) *Radiology suite.* The suite shall be designed and equipped in accordance with the following references:

a. National Council on Radiation Protection and Measurements Reports (NCRP), Nos. 33 and 49.

b. Iowa department of public health 641 IAC Chapters 38 to 41.

51.50(9) *Waste processing services—storage and disposal.* In lieu of the waste processing service requirements in the "Guidelines for Construction and Equipment of Hospital and Medical Facilities" in paragraph 51.50(2)*"a,"* space and facilities shall be provided for the sanitary storage and disposal of waste by incineration, mechanical destruction, compaction, containerization, removal or a combination of these techniques. These techniques must comply with the following environmental protection commission rules: 567 IAC rules 64.2(455B) and 64.3(455B); solid waste requirements of 567 IAC rules 101.1(455B,455D), 102.1(455B), 104.1(455B), and Chapters 106, 118 and 119; and air quality requirements of 567 IAC subrules 22.1(1) and 23.4(12) and paragraphs 23.1(2)*"ttt"* and 23.1(5)*"b."*

51.50(10) *Codes and standards.*

a. Nothing in the rules shall relieve the hospital from compliance with building codes, ordinances and regulations which are enforced by city, county, or state jurisdictions. Alterations shall not diminish the level of compliance with any codes, ordinances, regulations or standards below that which existed prior to the alterations. Any feature which does not meet the requirement for new buildings, but exceeds the requirement for existing buildings, shall not be further diminished. Features which exceed requirements for new construction need not be maintained. In no case shall any feature be less than that required for existing buildings.

b. Where conflict exists between local codes and state or federal regulations, the hospital shall request an appeal or approval of alternative provisions by the state building code commissioner, Iowa department of public safety, in accordance with procedures set out in 661 IAC subrules 16.110(7) and 16.110(9).

c. The codes and standards referenced in these minimum requirements can be obtained from the various agencies at the following addresses:

American Institute of Architects
1735 New York Avenue NW
Washington, D.C. 20006

American National Standards Institute
1430 Broadway
New York, NY 10018

National Council on Radiation Protection and Measurement
7910 Woodmont Avenue
Suite 1016
Bethesda, MD 20814

National Fire Protection Association
Batterymarch Park
Quincy, MA 02269

Iowa State Plumbing Code
Department of Public Health
Lucas State Office Building
Des Moines, IA 50319

Model Energy Code and Waste Processing Rules
Department of Natural Resources
Wallace State Office Building
Des Moines, IA 50319

Council of American Building Officials
5203 Leesburg Pike
Falls Church, VA 22041

State Building Code
Department of Public Safety
Wallace State Office Building
Des Moines, IA 50319

481—51.51(135B) Minimum standards for construction after July 8, 1998. Hospitals and off-site premises licensed under this chapter shall be built in accordance with these construction requirements. These rules apply to plans approved by the state fire marshal or local authority having jurisdiction after July 8, 1998, for new construction, renovations, additions, functional alterations, or changes in utilization to existing facilities.

51.51(1) *Variances.* Certain patient populations, conditions in the area, or the site may justify variances. In specific cases, variances to the rules may be granted by the director of the Iowa department of inspections and appeals after the following conditions are met:

a. The design and planning for the specific property shall offer improved or compensating features which provide equivalent desirability and utility;

b. Alternate or special construction methods, techniques, and mechanical equipment shall offer equivalent durability, utility, safety, structural strength and rigidity, sanitation, odor control, protection from corrosion, decay and insect attack, and quality of workmanship;

c. The health, safety or welfare of any patient shall not be endangered;

d. Variations are limited to the specific project under consideration and shall not be construed as establishing a precedent for similar acceptance in other cases;

e. Occupancy and function of the building shall be considered; and

f. Type of licensing shall be considered.

51.51(2) *General requirements.* Hospitals shall comply with the following guidelines and codes in the development of their building plans and construction of their facilities:

a. "Guidelines for Design and Construction of Hospital and Healthcare Facilities," 1996-97 edition, The American Institute of Architects Academy of Architecture for Health with assistance from the U.S. Department of Health and Human Services.

b. "The Model Energy Code," 1992 edition, Council of American Building Officials.

c. Special design considerations for persons with disabilities (patients, staff, and visitors) American National Standards Institute No. A117.1 and the Americans with Disabilities Act, Titles II and III.

d. State Building Code, 1997 edition.

51.51(3) *Life safety.* Facilities and construction shall be in accordance with National Fire Protection Association (NFPA) Standard 99 (Standards for Health Care Facilities—1996 edition), Standard 101 (Life Safety Code—1985 edition), and rules of local authorities. Facilities and construction shall be approved by the state fire marshal or local authority having jurisdiction.

51.51(4) *Elevator requirements.*

a. All facilities where either resident beds or other facilities for patients are not located on the first floor shall have electric or electrohydraulic elevators. The first floor is the floor first reached from the main front entrance.

b. Elevators shall comply with division of labor services rules as promulgated under Iowa Code chapter 89A and 875—Chapters 71 to 77.

51.51(5) *Plumbing requirements.* All plumbing and other pipe systems shall be designed and installed in accordance with the requirements of the Iowa Plumbing Code, 1996 edition, and applicable provisions of local ordinances.

51.51(6) *Mechanical requirements.* Pressure vessels, steam and hot water heating and domestic water heating systems shall comply with division of labor services rules promulgated under Iowa Code chapter 89 and 875—Chapters 204 to 209.

51.51(7) *Electrical requirements.* All electrical and electronic systems shall comply with NFPA Standard 70 National Electrical Code, 1996 edition.

51.51(8) *Radiology suite.* The suite shall be designed and equipped in accordance with the following references:

a. National Council on Radiation Protection and Measurements Reports (NCRP), Nos. 33 and 49.

b. Iowa department of public health 641—Chapters 38 to 41.

51.51(9) *Waste processing services—storage and disposal.* In lieu of the waste processing service requirements in the "Guidelines for Construction and Equipment of Hospital and Healthcare Facilities" in paragraph 51.51(2)*"a,"* space and facilities shall be provided for the sanitary storage and disposal of waste by incineration, mechanical destruction, compaction, containerization, removal or a combination of these techniques. These techniques must comply with the following environmental protection commission rules: rules 567—64.2(455B) and 64.3(455B); solid waste requirements of rules 567—101.1(455B,455D), 102.1(455B), 104.1(455B), and 567—Chapters 106, 118 and 119; and air quality requirements of 567—subrules 22.1(1) and 23.4(12) and paragraphs 23.1(2)*"ttt"* and 23.1(5)*"b."*

51.51(10) *Codes and standards.* See 481—subrule 51.50(10).

481—51.52(135B) Critical access hospitals. Critical access hospitals shall meet the following criteria:

51.52(1) The hospital shall be no less than 35 miles from another hospital or no less than 15 miles over secondary roads or shall be designated by the department of public health as a necessary provider of health care.

51.52(2) The hospital shall be a public or nonprofit hospital and shall be located in a county in a rural area.

51.52(3) The hospital shall provide 24-hour emergency care services as described in 481 IAC 51.30(135B).

51.52(4) The hospital shall maintain no more than 15 acute care inpatient beds or, in the case of a hospital having a swing-bed agreement, no more than 25 inpatient beds; and the number of beds used for acute inpatient services shall not exceed 15 beds.

51.52(5) The hospital shall meet the Medicare conditions of participation as a critical access hospital as described in 42 CFR Part 485, Subpart F as of October 1, 1997.

51.52(6) The hospital shall continue to comply with all general hospital license requirements as defined in 481 IAC 51.

These rules are intended to implement Iowa Code chapter 135B.

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††Two ARCs

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103.4(455B) Specific requirements for a sanitary landfill proposing to accept only construction and demolition waste
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103.7(455B) Coal combustion residue landfills

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107.6(455C) Rules relating to alcoholic liquor containers and wine containers purchased from state-owned liquor stores
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CHAPTER 108
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108.3(455B) Coal combustion residue
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CHAPTER 109
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CHAPTER 110
DESIGN, CONSTRUCTION AND OPERATION STANDARDS FOR SOLID WASTE MANAGEMENT FACILITIES

CHAPTER 111
FINANCIAL ASSURANCE REQUIREMENTS FOR MUNICIPAL SOLID WASTE LANDFILLS

CHAPTERS 112 to 116
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CHAPTER 117
REQUIREMENTS FOR WASTE TIRE FACILITIES

CHAPTER 118
DISCARDED APPLIANCE DEMANUFACTURING

CHAPTER 119
WASTE OIL

CHAPTER 118
DISCARDED APPLIANCE DEMANUFACTURING

567—118.1(455B,455D) Purpose. The purpose of this chapter is to implement Iowa Code chapter 455B, division IV, part 1, and section 455D.6(6) to ensure the proper removal and disposal of electrical parts containing polychlorinated biphenyls (PCBs), components containing mercury, and refrigerants (CFCs and HCFCs) from discarded appliances.

All appliances must be demanufactured before being recycled or disposed of. This chapter does not prevent the reuse or rebuilding of discarded appliances or components for their original purpose. This chapter does not apply to appliance service and repair shops unless they are in the business of demanufacturing discarded appliances. These rules do not apply to the removal of capacitors, refrigerants or components containing mercury during the maintenance or service of equipment containing such items.

567—118.2(455B,455D) Permit required.

118.2(1) No person that is now or plans to be involved in the demanufacturing of appliances is allowed to conduct any demanufacturing activities until an Appliance Demanufacturing Permit (ADP) has been obtained from the department of natural resources (DNR). The permit shall be issued for up to three years and is to be renewed every three years. The renewal application must be submitted to the solid waste section in the DNR central office in Des Moines a minimum of 30 days before permit expiration. This chapter does not apply to the removal of capacitors, refrigerants or components containing mercury during the maintenance or service of equipment containing such items.

118.2(2) Exceptions.

a. Any person engaged in the demanufacture of discarded appliances and registered with the department for removal and disposal of PCBs from appliances as of January 16, 2002, may continue such activity while applying for a permit provided:

(1) The department is notified within 30 days after January 16, 2002, of the person's intent to file a permit application; and

(2) A permit application is submitted within 90 days after January 16, 2002.

(3) If an appliance demanufacturing permit has not been obtained within one year of January 16, 2002, the appliance demanufacturer must cease appliance demanufacturing activities because of a lack of a permit.

b. Any person engaged in the demanufacture of appliances as of January 16, 2002, but not required to register because the pounds of capacitors removed is less than 200 pounds in a month or 500 pounds in a year, may continue such activity while applying for a permit provided:

(1) The department is notified within 30 days after January 16, 2002, of the person's intent to file a permit application; and

(2) A permit application is submitted within 90 days after January 16, 2002.

(3) If an appliance demanufacturing permit has not been obtained within one year of January 16, 2002, the appliance demanufacturer must cease appliance demanufacturing activities because of a lack of a permit.

118.2(3) Any person engaged in demanufacturing must be in compliance with all federal and state laws relating to the management and disposition of all hazardous wastes, hazardous materials and refrigerants.

567—118.3(455B,455D) Definitions.

"Appliances" means devices such as refrigerators, freezers, kitchen ranges, air-conditioning units, dehumidifiers, water heaters, furnaces, thermostats, clothes washers, clothes dryers, dishwashers, microwave ovens and commercial coolers containing capacitors, refrigerants, or components containing mercury that are discarded from all sources.

"Ballast" means an electrical device containing capacitors for the purpose of triggering high-level electrical components. A ballast provides electrical balance within the high-level electrical component circuitry.

"Capacitor" means a device for accumulating and holding a charge of electricity that consists of conducting surfaces separated by a dielectric.

"CFC" means chlorofluorocarbons, including any of several compounds used as refrigerants.

"CFR" means Code of Federal Regulations as amended through July 1, 2001.

"Demanufacturing" means the removal of components from discarded appliances including, but not limited to, capacitors, ballasts, mercury-containing components, fluorescent tubes, and refrigerants.

"Discarded" means no longer to be used for the original intended purpose.

"DOT-approved container" means those containers approved by the U.S. Department of Transportation, the agency responsible for shipping regulations for hazardous materials in the United States.

"Facility" means any landfill, transfer station, material recovery facility, salvage business, appliance service or repair shop, appliance demanufacturer, shredder operation or other party which may accept appliances for demanufacturing.

"Fixed facility" means a permitted appliance demanufacturer operating at a permanent location.

"Fluff" means the residual waste from the shredding operation after metals recovery.

"Hazardous condition" means any situation involving the actual, imminent or probable spillage, leakage, or release of a hazardous substance onto the land, into a water of the state or into the atmosphere which, because of the quantity, strength and toxicity of the hazardous substance, its mobility in the environment and its persistence, creates an immediate or potential danger to the public health or safety or to the environment.

"HCFC" means hydrochlorofluorocarbons, including any of several compounds used as refrigerants.

"Mercury-containing components" means devices containing mercury. Examples include, but are not limited to, thermostats, thermocouples, mercury switches and fluorescent tubes.

"Mobile operation" means a permitted appliance demanufacturer having equipment capable of operating in an area away from a fixed permitted location.

"PCB" or *"PCBs"* means polychlorinated biphenyl, which is a chemical substance that is limited to the biphenyl molecule that has been chlorinated to varying degrees, or any combination of such substances.

"Reclaim" means to reprocess refrigerant to an EPA ARI-700-88 standard.

"Recovery" means to remove all refrigerants to EPA standards.

567—118.4(455B,455D) Storage and handling of appliances prior to demanufacturing.

118.4(1) Any person collecting and storing discarded appliances must store them so as to prevent electrical capacitors, refrigerant lines and compressors, and components containing mercury from being damaged and allowing a release into the environment.

118.4(2) No method of handling discarded appliances may be used which in any way damages, cuts or breaks refrigerant lines or crushes compressors, capacitors, or mercury-containing components that may cause a release of refrigerant, PCBs or mercury into the environment.

118.4(3) No more than 1000 discarded appliances may be stored at a location prior to demanufacturing.

118.4(4) No discarded appliances may be stored for more than 180 days without demanufacturing.

567—118.5(455B,455D) Fixed facility and mobile operations. The following removal and disposal requirements must be met by both fixed and mobile facilities:

118.5(1) Demanufacturing of appliances must take place on an impervious floor (including but not limited to concrete, ceramic tile, or metal, but not wood). Any spills must be contained and picked up with proper equipment and procedures and properly disposed of.

118.5(2) The demanufacturing facility must be located 50 feet or more from a well and any water of the state. A permanent facility must meet local zoning requirements.

118.5(3) An applicant must establish a unique marking system, to be submitted with the permit application for DNR approval, signifying that all refrigerants, PCBs, and mercury-containing components have been removed. The unique marking system must be a minimum of nine inches square and must be applied to the appliances after demanufacturing.

567—118.6(455B,455D) Training. Beginning January 1, 2003, at least one owner or full-time employee of an appliance demanufacturing facility must have completed a DNR-approved training course covering, at a minimum, the following topics. A trained person must be on site at all times when discarded appliances are being demanufactured.

1. Regulations and procedures for the removal of refrigerant (CFCs, HCFCs, and ammonia) from appliances.
2. Regulations and procedures for the removal of PCB capacitors from appliances.
3. Regulations and procedures for the removal of mercury-containing components from appliances.
4. Regulations for the identification and removal of asbestos from ammonia-gas-operated refrigerators and air conditioners.
5. Safety issues.
6. Spill prevention and appliance cleanup procedures appropriate for appliance demanufacturing.
7. Proper storage, transportation, and disposal requirements for all recovered wastes from the appliance demanufacturing process.
8. The proper methods of loading and unloading discarded appliances.
9. Hands-on training in the demanufacturing process.

567—118.7(455B,455D) Appliance demanufacturing permit application requirements.

118.7(1) The permit application for appliance demanufacturing must contain the following information to be submitted on Form 542-8005.

a. Facility name.

b. Office address.

c. Location of demanufacturing facility if different from office address.

d. Contact person or official responsible for the operation of the facility.

e. Type, source and expected number or weight of appliances to be handled per year.

f. Schematic site plans of a fixed facility including the schematic floor plans of any buildings showing where activities will take place and where waste is stored.

g. For mobile operations, provide schematic plans, or a description and photographs, of the mobile van or trailer.

h. A copy of the EPA Refrigerant Recovery or Recycling Device Acquisition Certification certifying that the equipment meets EPA requirements.

i. Operation plan: a detailed summary of the activities that will be performed on each type of appliance that will be considered for demanufacturing. This summary must include step-by-step activities of the demanufacturing process.

j. A contingency plan detailing specific procedures to be used in case of equipment breakdown or fire, including methods to be used to remove or dispose of accumulated waste.

k. A copy of the Authorization to Discharge (Stormwater) Permit number where applicable.

l. A copy of EPA notification of PCB activity. Facilities with a PCB storage area must register with Form 7710-53. This form may be obtained by contacting Fibers and Organics Branch, Office of Pollution Prevention and Toxics, United States Environmental Protection Agency, Ariel Rios Building (7404), 1200 Pennsylvania Avenue NW, Washington, DC 20460.

m. Submittal of documentation showing compliance with rule 118.6(455B,455D).

n. A copy of the unique marking system to be applied to each discarded appliance after demanufacturing.

118.7(2) Applications for permit renewal must address any changes to the information previously submitted pursuant to subrule 118.7(1). If there has been no change in an item, the applicant shall indicate such on the application form.

118.7(3) An application for permit amendment must be submitted and the amendment issued by the DNR before significant changes may be made by the permit holder to the process or facility.

567—118.8(455B,455D) Inspections.

118.8(1) Existing registered facilities and existing facilities that were previously exempt from registration will be inspected by DNR prior to issuance of the initial demanufacturing permit. The permit will not be issued until the initial inspection report shows that the facility is in compliance with the proposed permit and these rules.

118.8(2) New facilities (facilities not in operation on January 16, 2002) will be inspected by DNR prior to start-up. The initial inspection will be completed within 30 days of receipt of notice from the permit holder stating that the facility is ready for inspection. The facility may not start operation until the permit holder is notified by DNR that the initial inspection shows the facility is in compliance with the permit and these rules.

118.8(3) Appliance demanufacturing facilities will be inspected regularly by DNR.

567—118.9(455B,455D) Refrigerant removal requirements.

118.9(1) All owners of refrigerant recovery and recycling equipment must provide certification to EPA that they have acquired and are using EPA-approved equipment.

118.9(2) Refrigerants in appliances must be recovered to EPA standards using equipment meeting EPA requirements (40 CFR Part 82.162), or the person certified to remove refrigerants must verify that the refrigerant has been removed from the appliance before the appliance is removed for recycling or disposal.

118.9(3) The removal of refrigerants from refrigeration appliances must take place in an area where the temperature of the surrounding air and of the appliance being demanufactured is 45 degrees Fahrenheit or greater.

118.9(4) Facilities that are not EPA-certified refrigerant reclaimers must ship recovered refrigerant to an EPA-certified reclamation facility or properly dispose of the refrigerant at an EPA-permitted facility. Reclamation may only take place on site if the appliance demanufacturing facility is certified as a reclaimer by the EPA. Any refrigerants that cannot be reclaimed or recycled must be properly disposed of by incineration or other acceptable means.

118.9(5) Compressor oil.

a. Compressor oil from refrigeration unit compressors may be removed during the demanufacturing process, and any oil removed must be stored in accordance with 567—119.5(455D,455B).

b. Compressor oils are not hazardous and may be burned in used-oil-fired space heaters provided the heaters have a capacity of 0.5 BTUs (British thermal units) per hour or more.

c. Compressor oils may be sold to a marketer of used oil.

118.9(6) Ammonia-gas-operated refrigerators and air conditioners.

a. Ammonia gas must be vented into water.

b. Sodium chromate must be removed from refrigeration equipment containing sodium chromate.

c. Sodium chromate liquid is a hazardous waste and must be disposed of at an EPA-permitted facility.

d. Removal of sodium chromate liquid must take place on an impervious surface. In case of a spill, the spilled liquid and the material used as absorbent must be handled as a hazardous waste and disposed of as a hazardous waste.

e. Sodium chromate must be stored in a DOT-approved container that shows no sign of damage. The container must be labeled with a proper EPA-approved chromium label stating "chromium" or "hazardous waste" (40 CFR Part 262.32 and 49 CFR Part 172.304) in both English and the predominant language of any non-English reading workers.

f. Prior to shipment, sodium chromate must be packaged to prevent leakage, and all containers must be sealed.

g. Persons generating sodium chromate waste must obtain an EPA identification number and maintain records to determine if they are small- or large-quantity hazardous waste generators based on a yearly accumulation.

h. Asbestos insulation found on refrigerant lines must be removed. Proper protective equipment must be used and proper procedures must be followed when removing asbestos. Safety requirements shall comply with Occupational Safety and Health Administration (OSHA) regulations.

i. Asbestos must be moistened and double bagged, in accordance with 40 CFR Part 61.150, prior to disposal at the approved landfill for the person's area. A person who needs to dispose of asbestos must contact the landfill and make arrangements for the disposal and further packaging and handling procedures.

567—118.10(455B,455D) Mercury-containing component removal and disposal requirements.

118.10(1) All components containing mercury shall be removed from appliances. Precautions shall be taken to prevent breakage of the mercury-containing components and the release of mercury.

118.10(2) All mercury-containing component storage containers must be labeled with the proper EPA-approved mercury label stating "mercury" or "hazardous waste" (49 CFR Part 262.34(a)(2)) in both English and the predominant language of any non-English-reading workers. In addition to the label, the date when the first mercury-containing component was placed in the container must be affixed on the container (40 CFR Part 162). Storage of mercury is limited to one year after which it must be transported to an EPA-approved recycler.

118.10(3) All mercury containers must be sealed prior to shipment.

118.10(4) All components containing mercury must be disposed of at an EPA-approved mercury recycling/recovery facility.

118.10(5) Fluorescent tubes, lamps, bulbs, and similar items must be placed in a container and packaged to prevent breakage for shipment to an EPA-approved recycler or processed in a manner in compliance with state and federal regulations.

567—118.11(455B,455D) Capacitor removal requirements.

118.11(1) All capacitors must be removed from discarded appliances.

118.11(2) All capacitors are assumed to contain PCBs unless proven otherwise by an approved laboratory, unless the words "No PCBs" have been imprinted on the body of the capacitor by the manufacturer, or unless the manufacturer certifies in writing that no PCBs were used in the manufacture of the appliance or capacitor.

118.11(3) All PCB capacitors must be disposed of in accordance with subrule 118.11(5).

118.11(4) Capacitors that are proven not to contain PCBs may be disposed of or recycled as any other nonhazardous solid waste.

118.11(5) Containers for storage and disposal of PCB items. PCB capacitors must be stored and transported according to the Toxic Substances Control Act (TSCA) (40 CFR Part 761) and disposed of at a TSCA-permitted disposal facility. Facilities used for the storage of PCB items designated for disposal must meet the following storage requirements:

a. PCB items must be stored in a manner that provides adequate protection from the elements and adequate secondary containment. This storage must take place on an impervious material.

b. The site must be located above the 100-year flood water elevation.

c. All capacitors containing or suspected of containing PCBs must be placed in a DOT-approved container that shows no signs of damage. The bottom of the container must be filled to a depth of two inches with absorbent material such as sand, oil-dry, or kitty litter.

d. All DOT-approved containers must be affixed with an EPA-approved 6" x 6" yellow label stating "PCBs" (40 CFR Part 761.45) in both English and the predominant language of any non-English-reading workers.

e. The date when the first capacitor was placed in the container must also be placed on the container.

f. Nonleaking small PCB capacitors may be stored for up to 30 days from the date of removal in an area that does not comply with the requirements in 118.11(5)*"a"* to *"e"* provided a notation is placed on the PCB item indicating the date the item was removed from the appliance.

g. All containers must be sealed prior to shipment.

h. Capacitors may be stored for no more than 270 days.

118.11(6) Transportation. The labeled and dated container must be transported by an EPA-approved PCB transporter using an EPA Uniform Hazardous Waste form. From the first date entered on the container, the demanufacturer has one year to have the contents buried at a TSCA landfill or incinerated at a TSCA disposal facility (40 CFR Part 761.65). This burial or incineration must be documented and this record kept by the demanufacturer for three years from the date the PCB waste was accepted by the initial transporter.

567—118.12(455B,455D) Spills.

118.12(1) Any spills from leaking or cracked capacitors must be handled by placing the capacitor and any contaminated rags, clothing, and soil into a container for shipment to an EPA-approved waste disposal facility. Spills of liquid PCBs which occur outside a DOT-approved container must be cleaned and the cleanup verified by sampling as described at 40 CFR Part 761.130. Detailed records of such cleanups and sampling must be maintained as described at 40 CFR Part 761.180.

118.12(2) Mercury spill kits (with a mercury absorbent in the kits) must be on hand and used in the event of a mercury spill. Any waste from the cleanup of a mercury spill must be disposed of as a hazardous waste.

118.12(3) In the event a spill results in a hazardous condition, the facility must notify the department of natural resources at (515)281-8694 and the local police department or the sheriff's office of the affected county of the occurrence of a hazardous condition as soon as possible, but no later than six hours after the onset or discovery of a spill.

567—118.13(455B,455D) Record keeping and reporting.

118.13(1) A permitted appliance demanufacturing facility shall keep the following records on a calendar-year basis:

a. The name of the facility or facilities to which demanufactured appliances were shipped, the date of each shipment, the weight of appliances in each shipment and the name and address of the transporter.

b. The name of the facility to which components containing mercury were shipped, including fluorescent tubes, the date of each shipment, the number of components and number of tubes shipped and the name and address of the transporter.

c. The name of the facility to which sodium chromate was shipped for disposal, the date of each shipment, the amount shipped and the name and address of the transporter.

d. The name of the facility to which refrigerants were shipped to be reclaimed, the date of each shipment, the amount shipped and the name and address of the transporter.

e. The name of the facility to which refrigerants were shipped to be disposed of, the date of each shipment, the amount shipped and the name and address of the transporter.

f. The name of the facility to which PCB capacitors and ballasts were shipped, the date of each shipment, the weight of capacitors shipped and the name and address of the transporter.

118.13(2) Annual reports with the information required in subrule 118.13(1) are:

a. To be sent to the solid waste section in the DNR central office in Des Moines, and a copy to the appropriate field office;

b. Due January 31 each year for the activities of the previous calendar year;

c. To be submitted on forms provided by the department, which may be submitted electronically when the electronic format is completed; and

d. To be retained by the permit holder for at least three years.

567—118.14(455B,455D) Shredding of appliances.

118.14(1) Fluff from the shredding of demanufactured appliances must be sampled quarterly, at a minimum, and analyzed according to Test Methods for Evaluation of Solid Waste, Physical-Chemical Methods SW 846, USEPA, Third Edition 1986, for the presence of PCBs, and according to the toxicity characteristic leaching procedure (TCLP) for lead and mercury. The waste shall be sampled once a day for seven consecutive working days to make a composite sample. If the total PCB amount is less than 50 ppm and if the TCLP results for mercury and lead are below 0.20 ppm and 5.0 ppm, respectively, the fluff may be landfilled.

118.14(2) No person or facility in the state may shred, crush, or bale any appliances that have not been demanufactured.

These rules are intended to implement Iowa Code sections 455B.304 and 455D.6(6).

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CHAPTER 119
WASTE OIL

567—119.1(455D,455B) Authority, purpose, and applicability.

119.1(1) *Authority.* Pursuant to Iowa Code sections 455D.7(1), 455D.6(6), and 455B.304, the environmental protection commission is given the authority to adopt rules regulating the disposal, collection, and reuse of waste oil.

119.1(2) *Purpose.* The purpose of these rules is to protect the public health and the environment by regulating the disposal and collection of waste oil and to promote the reuse of oil which is a limited energy resource.

119.1(3) *Applicability.* The provisions of this chapter apply to oil retailers, sanitary disposal project permittees, and persons involved in the collection of waste oil.

567—119.2(455D,455B) Definitions. The following definitions apply to the provisions of this chapter:

"Contaminated" means waste oil mixed with hazardous waste as defined by the resource conservation and recovery Act or with incompatible wastes including, but not limited to: antifreeze, solvents, paints, pesticides, or household hazardous materials. Minimal amounts of vehicle fuel shall not be considered an incompatible waste.

"Customer" means any individual who purchases oil or generates waste oil for personal or family purposes, including a farmer or a farm household.

"Department" means the department of natural resources.

"Division" means the waste management authority division of the department.

"Lubricating oils" means engine lubricating oils, hydraulic fluids and gear oils, excluding marine and aviation oils.

"Recycling" means the preparation of used oil for reuse as a petroleum product by rerefining, reprocessing, reclaiming, or other means or to use used oil as a substitute for a petroleum product made from new oil, provided that the preparation or use is operationally safe, environmentally sound, and complies with all federal and state laws.

"Retailer" means a person offering for sale or selling a petroleum-based or synthetic oil to the ultimate consumer or user of the product, as an over-the-counter product or whereby the consumer is charged separately for the oil product when coupled with a service.

"Tank" means a closable stationary or mobile device designed to contain an accumulation of waste oil and constructed of nonearthen materials (e.g., concrete, steel, plastic) that provide structural support.

"Waste oil" means any petroleum-based or synthetic oil which through its use, storage, or handling has become unsuitable for its original purpose due to the presence of chemical or physical impurities. Waste oil includes, but is not limited to, the following:

1. Spent lubricating fluids which have been removed from an engine crankcase, transmission, gearbox, or differential of an automobile, bus, truck, vessel, plane, heavy equipment, or machinery powered by an internal combustion engine.
2. Spent industrial oils, including compressor, turbine, bearing, hydraulic, metalworking, electrical, and refrigerator oils.

Waste oil does not include oil which has been contaminated or contains PCBs of 5ppm or greater.

"Waste oil collection site" means any commercial, municipal, or nonprofit establishment or operation which has a waste oil collection tank on the premises, and accepts waste oil for temporary storage prior to the recycling of that which is collected.

"Waste oil collector" means any sanitary landfill operator, sanitary disposal project operator, oil retailer, or other individual who operates a waste oil collection site.

567—119.3(455D,455B) Prohibited disposal.

119.3(1) Waste oil shall not be accepted for final disposal at any sanitary landfill. However, a sanitary landfill or sanitary disposal project, as defined in Iowa Code section 455B.301, may accept waste oil for temporary storage or collection if the ultimate disposition of the oil is for recycling. All necessary permits or permit conditions must be obtained prior to the storage or collection of waste oil at these landfills and projects.

119.3(2) Rescinded IAB 8/18/93, effective 9/22/93.

567—119.4(455D,455B) Operational requirements.

119.4(1) *Collection.* Sanitary landfill operators, sanitary disposal project operators, commercial waste oil collectors, oil retailers, or other individuals who choose to collect waste oil from customers shall comply with the following requirements:

a. Waste oil shall be accepted which is contained in a closed, unbreakable, preferably reusable, container.

b. Waste oil collectors shall provide supervision of the collection process to minimize the risk of spills and to prevent customers from depositing contaminated waste oil into the collection tank. However, this does not preclude designating unsupervised drop-off sites for waste oil as long as the following conditions are met:

(1) Only sealed containers of five gallons or less shall be accepted.

(2) The designated drop-off site must be wholly or partially sheltered from the elements.

(3) Customers shall drop off their containers only at the designated site and are not permitted to deposit their waste oil into a collection tank.

(4) The designated site must be located on an impermeable surface engineered to contain potential spills.

c. During noncollection hours, the tank must be secured to prevent the contamination of the collected waste oil.

d. A sign shall be placed on or near the waste oil collection tank which includes the information that this tank is for waste oil collection only and the depositing of other materials is prohibited.

e. Collectors of waste oil shall ensure that the ultimate disposition of waste oil collected is for recycling and reuse.

f. There is no obligation to accept contaminated oil from the customer.

g. Waste oil collectors shall comply with Iowa Code section 455B.386 when actual or imminent oil spills pose a threat to the public health or the environment.

119.4(2) *Retailers.* In addition to the above requirements relating to waste oil collection, retailers also shall comply with the following:

a. A sign shall be placed near the point of sale which informs the customer that it is unlawful to dispose of waste oil at a sanitary landfill, and that customers should return their waste oil to waste oil collection sites for recycling and reuse.

b. Retailers who choose to collect waste oil shall accept waste oil generated by residential households or farmers, but are not required to collect waste oil generated by commercial or municipal establishments.

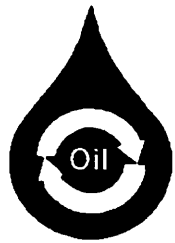
c. Waste oil shall be accepted during normal business hours.

d. Retailers who choose not to collect waste oil shall post a durable, legible sign at least 8½" by 11" in size and containing the following information:

(1) The language "RECYCLE USED OIL" in bold lettering;

(2) A list of the benefits from recycling waste oil including, but not limited to, "conserves energy, reuses limited resources, and protects Iowa's drinking water";

(3) At least 2 inches in length, the federal Environmental Protection Agency's oil recycling symbol as shown below;



(4) The language "used oil is a household hazardous material" and, at least 2 inches in length, the household hazardous materials program symbol as shown below;

(5) The groundwater protection hotline telephone number referenced as a source for more information on used oil recycling;

(6) The warning that the disposal of waste oil in a landfill or its deposit or discharge into any state waterway is unlawful;

(7) The name, address and location of at least one used oil collection site located within the county in which the retailer is located. If there is more than one used oil collection site located in the applicable county, then the nearest collection site shall be listed on the posted sign.

Retailers shall ensure that the mandated signs are located according to the provisions listed above. Retailers may obtain the required signs upon request from the department. Retailers choosing to print and post their own signs must obtain a variance from the departmental rules. Signs must be at least 8½" by 11" in size and contain the information stipulated above. To request a variance, retailers should forward to the division for review the sign they wish to substitute for the departmental sign.

Those retailers who do not sell any other household hazardous materials except for motor oil products may comply with the household hazardous materials informational sign posting requirement of 567—Chapter 144 through compliance with this chapter.

567—119.5(455D,455B) Tanks.

119.5(1) *Aboveground.* In addition to the requirements imposed by the office of the state fire marshal, the following standards are applicable to aboveground waste oil collection tanks:

a. The tank shall be of sufficient size to handle the projected quantities of used oil to be returned to this specific collection site.

b. The tank shall be designed and maintained to prevent the spillage or discharge of waste oil. Tanks must be set upon an impermeable surface engineered to contain potential spills.

c. Absorbent material shall be available at the tank site for use by the operator to control waste oil spillage or discharge.

d. The tank shall have a level gauge or some other adequate means for checking the oil level within the tank.

e. The tank shall be constructed in accordance with American Petroleum Institute specifications and standards.

119.5(2) *Underground.* Underground storage tanks used to collect or store waste oil shall comply with the standards in part 8 of division IV of Iowa Code chapter 455B, entitled "Underground Storage Tanks," and the promulgated rules, Iowa Administrative Code, 567—Chapters 135 and 136.

567—119.6(455D,455B) Locating collection sites. If the retailer is unaware of any locations within the county where waste oil is being accepted from customers, then the retailer shall cooperate with other retailers to identify a waste oil collection site for customers. To identify a waste oil collection site, retailers should consider recruiting an operator of a facility which already has the means to collect waste oil. If through this cooperative effort no sites can be identified, then the retailer should consider accepting waste oil from customers according to the standards listed in this chapter.

567—119.7(455D,455B) Waste management authority division responsibilities.

119.7(1) *Groundwater protection hotline.* The division will promote the recycling of used oil through the continued staffing of the groundwater protection hotline. Staff will provide general information, distribute written materials concerning waste oil recycling, and maintain an updated, statewide list of waste oil collection facilities. Using the groundwater protection hotline, customers should contact division staff to determine environmentally acceptable disposal methods for contaminated waste oil.

119.7(2) *County coordinators.* The division will designate, when feasible, waste oil recycling coordinators for each county to promote waste oil recycling, to identify existing waste oil collection sites, and to help establish additional collection sites.

567—119.8(455D,455B) State procurement. All state officials shall promote the procurement and purchase of lubricating oils and other petroleum products that are made from recycled oils. Recycled oils which meet state specifications are recommended for use as engine lubricants in state vehicles, as hydraulic and gear lubricants for heavy equipment and machinery, and as a fuel oil for backup heating systems at state facilities with fuel oil heating systems.

These rules are intended to implement Iowa Code sections 455D.6(6) and 455D.13 and chapter 455B, division IV, part 1.

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[Filed 7/30/93, Notice 4/14/93—published 8/18/93, effective 9/22/93]

i. Any employee who participates in this early retirement program and who is later approved for state group disability benefits is exempt from further participation in this program. In addition, the state's share of insurance premiums already paid, from the time of termination until long-term disability payments begin, may be recouped by the state and returned to the department of management for repayment to the originating fund. However, any program participant's payment toward health insurance premiums during that period will be applied toward the employee's cost of the coverage.

11.1(4) *Sick leave and vacation incentive program—2002.*

a. This termination incentive program is provided for in 2001 Iowa Acts, Senate File 551. To be eligible to participate in this program an employee's length of credited service and the employee's age as of December 31, 2002, but for participation in this program, must equal or exceed 75 years, including buy-back or buy-in service in the Iowa public employees' retirement system (IPERS) or in the public safety peace officers' retirement, accident, and disability system (POR). Employees on the payroll who meet these criteria and who are receiving workers' compensation on and after November 20, 2001, are also eligible to participate.

(1) Age shall be determined in years and quarters of a year.

1. The birth year is subtracted from 2002 to obtain the total years.
2. To calculate quarters:

- If the birth month is January, February, or March, one year shall be added to the total years calculated in 11.1(4)*"a"*(1)"1";
- If the birth month is April, May, or June, .75 of a year shall be added to the total years calculated in 11.1(4)*"a"*(1)"1";
- If the birth month is July, August, or September, .50 of a year shall be added to the total years calculated in 11.1(4)*"a"*(1)"1";
- If the birth month is October, November, or December, .25 of a year shall be added to the total years calculated in 11.1(4)*"a"*(1)"1."

(2) Length of credited service shall be calculated by IPERS or POR service credit, pursuant to each system's respective rules and regulations.

b. To become a program participant, an employee must complete and file a program application form on or before January 31, 2002, and must terminate employment on or before February 1, 2002.

c. For purposes of this program, the following definitions shall apply:

"Employee" means an employee of the executive branch of the state who is not covered by a collective bargaining agreement, including an employee of a judicial district of the department of correctional services if the district elects to participate in the program, an employee of the state board of regents if the board elects to participate in the program, and an employee of the department of justice. However, "employee" does not mean an elected official.

"Participating employee" means an eligible employee who, on or before January 31, 2002, submits an election to participate in the sick leave and vacation incentive program and terminates state employment on or before February 1, 2002. For the purposes of this program, a person remains a participating employee after payments made hereunder cease.

"Regular annual salary" means the employee's regular biweekly salary on the date of termination multiplied by 26.

d. A participating employee will receive the cash value of the employee's accumulated sick leave, not to exceed 100 percent of the employee's regular annual salary, and annual leave accrued balances. The state shall pay to the participating employee a portion of the combined dollar value of the accrued sick leave and annual leave balances each fiscal year, for a period of five years on the following schedule:

(1) Upon termination, in the first fiscal year of the program, the employee shall receive 10 percent of the total cash value of the aforementioned calculation for sick leave and annual leave.

(2) In August of the second through the fourth fiscal years of the program, the employee shall receive 20 percent of the total cash value of the aforementioned calculation for sick leave and annual leave.

(3) In August of the fifth fiscal year of the program, the employee shall receive the remaining 30 percent of the total cash value of the aforementioned calculation for sick leave and annual leave.

e. A participating employee, as a condition of participation in this program, shall waive any and all rights to receive payment of a sick leave balance pursuant to Iowa Code section 70A.23 and payment for accrued vacation pursuant to Iowa Code section 91A.4 and shall waive all rights to file suit against the state of Iowa, including all of its departments, agencies, and other subdivisions, based on state or federal claims arising out of the employment relationship.

f. The administrative head, manager, supervisor, or any employee of a department, agency, board, or commission of the state of Iowa shall not coerce or otherwise influence any state employee to participate or not participate in this program.

g. In the event a program participant dies prior to receiving the total cash value of the incentive addressed in paragraph 11.4(1)*"d,"* the participant's designated beneficiary or beneficiaries shall receive the remaining payments on the schedule developed for such payments.

h. An employee who elects participation in this program, from the date of termination from employment, is not eligible to accept any further permanent employment with the state of Iowa. This prohibition does not apply to a program participant who is later elected to public office.

581—11.2(19A) Disciplinary actions. Except as otherwise provided, in addition to less severe progressive discipline measures, any employee is subject to any of the following disciplinary actions when based on a standard of just cause: suspension, reduction of pay within the same pay grade, disciplinary demotion, or discharge. Disciplinary action involving employees covered by collective bargaining agreements shall be in accordance with the provisions of the agreement. Disciplinary action shall be based on any of the following reasons: inefficiency, insubordination, less than competent job performance, failure to perform assigned duties, inadequacy in the performance of assigned duties, dishonesty, improper use of leave, unrehabilitated substance abuse, negligence, conduct which adversely affects the employee's job performance or the agency of employment, conviction of a crime involving moral turpitude, conduct unbecoming a public employee, misconduct, or any other just cause.

11.2(1) Suspension.

a. Suspension pending investigation. An appointing authority may suspend an employee for up to 21 calendar days with pay pending an investigation. If, upon investigation, it is determined that a suspension without pay was warranted as provided in 11.2(1)*"b"*(1) below for an employee covered by the premium overtime provisions of the Fair Labor Standards Act, the appointing authority shall recover the pay received by th

b. Disciplinary suspension. An appointing authority may suspend an employee for a length of time considered appropriate not to exceed 30 calendar days as provided in either subparagraph (1) or (2) below. A written statement of the reasons for the suspension and its duration shall be sent to the employee within 24 hours after the effective date of the action.

(1) Employees who are covered by the premium overtime provisions of the federal Fair Labor Standards Act may be suspended without pay.

(2) Employees who are exempt from the premium overtime provisions of the federal Fair Labor Standards Act will not be subject to suspension without pay except for infractions of safety rules of major significance, and then only after the appointing authority receives prior approval from the director. Otherwise, when a suspension is imposed on such an employee, it shall be with pay and shall carry the same weight as a suspension without pay for purposes of progressive discipline. The employee will perform work during a period of suspension with pay unless the appointing authority determines that safety, morale, or other considerations warrant that the employee not report to work.

11.2(2) Reduction of pay within the same pay grade. An appointing authority may reduce the pay of an employee who is covered by the overtime provisions of the federal Fair Labor Standards Act to a lower step or rate of pay within the same pay grade assigned to the employee's class for any number of pay periods considered appropriate. A written statement of the reasons for the reduction and its duration shall be sent to the employee within 24 hours after the effective date of the action, and a copy shall be sent to the director by the appointing authority at the same time.

Employees who are exempt from the overtime provisions of the federal Fair Labor Standards Act will not be subject to reductions of pay within the same pay grade except for infractions of safety rules of major significance, and then only after the appointing authority receives prior approval from the director.

11.2(3) Disciplinary demotion. A disciplinary demotion may be used to permanently move an employee to a lower job classification. A temporary disciplinary demotion shall not be used as a substitute for a suspension without pay or reduction in pay within the same pay grade. An employee receiving a disciplinary demotion shall only perform the duties and responsibilities consistent with the class to which demoted. An appointing authority may disciplinary demote an employee to a vacant position. In the absence of a vacant position, the appointing authority may effect the same disciplinary result by removing duties and responsibilities from the employee's position sufficient to cause it to be reclassified to a lower class. A written statement of the reasons for the disciplinary demotion shall be sent to the employee within 24 hours after the effective date of the action, and a copy shall be sent to the director by the appointing authority at the same time.

No disciplinary demotion shall be made from one position covered by merit system provisions to another, or from a position not covered by merit system provisions to one that is, until the employee is approved by the director as being eligible for appointment. Disciplinary demotion of an employee with probationary status to a position covered by merit system provisions shall be in accordance with 581—subrule 9.2(2).

An agency may not disciplinarily demote an employee from a position covered by merit system provisions to a position not covered by merit system provisions without the affected employee's written consent regarding the change in coverage. A copy of the consent letter shall be forwarded by the appointing authority to the director. If the employee does not consent to the change in coverage, a reduction in force may be initiated in accordance with these rules or the applicable collective bargaining agreement provisions.

11.2(4) Discharge. An appointing authority may discharge an employee. Prior to the employee being discharged, the appointing authority shall inform the employee during a face-to-face meeting of the impending discharge and the reasons for the discharge, and at that time the employee shall have the opportunity to respond. A written statement of the reasons for the discharge shall be sent to the employee within 24 hours after the effective date of the discharge, and a copy shall be sent to the director by the appointing authority at the same time.

When an employee occupies a position where a current qualification for appointment is based upon the required possession of a temporary work permit or on the basis of possession of a license or certificate, and that document expires, is revoked or is otherwise determined to be invalid, the employee shall either be discharged for failure to meet or maintain license or certificate requirements, or otherwise appointed to another position in accordance with these rules. This action shall be effective no later than the pay period following the failure to obtain, revocation of, or expiration of the permit, license, or certificate.

When an employee occupies a position where a current qualification for appointment is based upon the requirement of an approved background or records investigation and that approval is later withdrawn or unobtainable, the employee shall be immediately discharged for failure to maintain those background or records requirements or may be appointed to another position in accordance with these rules.

11.2(5) Appeal of a suspension, reduction of pay within the same pay grade, disciplinary demotion or discharge shall be in accordance with 581—Chapter 12. The written statement to the employee of the reasons for the discipline shall include the verbatim content of 581—subrule 12.2(6).

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**IAB Personnel Department

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PUBLIC HEALTH DEPARTMENT[641]

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CHAPTER 1
NOTIFICATION AND SURVEILLANCE OF REPORTABLE COMMUNICABLE AND INFECTIOUS DISEASES, POISONINGS AND CONDITIONS

[Prior to 7/29/87, Health Department[470]]

641—1.1(139A) Definitions. For the purpose of these rules, the following definitions shall apply:

"Acute hearing loss and tinnitus" means any sudden deafness, hearing loss, or tinnitus due to exposure to noise in the work setting. (International Classification of Diseases, Tenth Edition, (ICD-10) codes H83.3, H90.2, H90.3, H91.2, H93.1, and H93.2)

"Acute or chronic respiratory conditions due to fumes, vapors or dusts" means acute chemical bronchitis, any acute, subacute, or chronic respiratory condition due to inhalation of a chemical fume or vapor, or pneumoconioses not specifically listed elsewhere in these rules. (ICD-10 codes J63.0-J64, J66, and J68.0-J68.9) "Acute or chronic respiratory conditions due to fumes, vapors or dusts" excludes those respiratory conditions related to tobacco smoke exposure.

"Agriculturally related injury" means any injury to a farmer, farm worker, farm family member, or other individual which occurred on a farm, or in the course of handling, producing, processing, transporting or warehousing farm commodities.

"Carpal tunnel or related neuropathy" means carpal tunnel syndrome, other lesions of the median nerve, ulnar nerve or radial nerve, causalgia or other related neuropathy of the upper limb. (ICD-10 codes G56.0-G56.9)

"Clinical laboratory" means any laboratory performing analyses on specimens taken from the body of a person in order to assess that person's health status.

"Communicable disease" means any disease spread from person to person or animal to person.

"Contagious or infectious disease" means any contagious or infectious disease which is transmitted by a bloodborne route or by skin-to-skin contact.

"Health care facility" means a health care facility as defined in Iowa Code section 135C.1, an ambulatory surgical center, or a clinic.

"Health care provider" means a person licensed to practice medicine and surgery, osteopathic medicine and surgery, osteopathy, chiropractic, podiatry, nursing, dentistry, optometry, or licensed as a physician assistant, dental hygienist, or acupuncturist.

"Occupationally related asthma, bronchitis or respiratory hypersensitivity reaction" means any extrinsic asthma or acute chemical pneumonitis due to exposure to toxic agents in the workplace. (ICD-10 codes J67.0-J67.9)

"Poison control or poison information center" means any organization or program which has as one of its primary objectives the provision of toxicologic and pharmacologic information and referral services to the public and to health care providers (other than pharmacists) in response to inquiries about actual or potential poisonings.

"Raynaud's phenomenon" means ischemia of fingers, toes, ears or nose including "vibration white finger" caused by exposure to heat, cold, vibration or other physical agents in the work setting. (ICD-10 code I73.0)

"Severe skin disorder" means those dermatoses, burns, and other severe skin disorders which result in death or which require hospitalization or other multiple courses of medical therapy.

"Sexually transmitted disease or infection" means a disease or infection that is primarily transmitted through sexual practices.

"Toxic agent" means any noxious substance in solid, liquid or gaseous form capable of producing illness in humans including, but not limited to, pesticides, heavy metals, organic and inorganic dusts and organic solvents. Airborne toxic agents may be in the form of dusts, fumes, vapors, mists, gases or smoke.

"Toxic hepatitis" means any acute or subacute necrosis of the liver or other unspecified chemical hepatitis caused by exposure to nonmedicinal toxic agents other than ethyl alcohol including, but not limited to, carbon tetrachloride, chloroform, tetrachloroethane, trichloroethylene, phosphorus, TNT, chloronapthalenes, methylenedianilines, ethylene dibromide, and organic solvents. (ICD-10 codes K71.0-K71.9)

641—1.2(139A) Director of public health. The director of public health is the principal officer of the state to administer disease reporting and control procedures.

641—1.3(139A) Reportable diseases. Reportable diseases are those diseases or conditions listed in subrules 1.3(1) and 1.3(2). The director of public health may also designate any disease, condition or syndrome temporarily reportable for the purpose of a special investigation. Each case of a reportable disease is required to be reported to the Iowa Department of Public Health, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319-0075, by the physician or other health practitioner attending any person having a reportable disease and by laboratories performing tests identifying reportable diseases.

1.3(1) *List of reportable diseases or conditions.*

a. Specific communicable diseases.

(1) Common diseases:

†Acquired immune deficiency syndrome (AIDS) and AIDS-defining conditions
#Aeromonas
Campylobacteriosis
†Chlamydia
Cryptosporidiosis
Encephalitis, arboviral
~Enterococcus invasive disease
#Enterohemorrhagic Escherichia coli (non-O157:H7)
~Escherichia coli O157:H7 related diseases (includes HUS)
Giardiasis
†Gonorrhea
~Group A Streptococcus invasive disease
~*Haemophilus influenza type B invasive disease
Hepatitis, types A, †B, C, D, and E
†Human immunodeficiency virus (HIV) infection, including HIV-exposed newborn infant (i.e., newborn infant whose mother is infected with HIV)
Legionellosis
Lyme disease
*Measles (rubeola)
~*Meningococcal invasive disease
~Methicillin-resistant Staphylococcus aureus invasive disease
#Norwalk-like virus
Pertussis
Rabies (animal and *human)
~Salmonellosis (including Typhoid fever)
~Shigellosis

*Diseases which are noted with an asterisk should be reported IMMEDIATELY by telephone 1-800-362-2736.
~Isolates of organisms from diseases so noted should be sent to the University of Iowa Hygienic Laboratory.
†Sexually transmitted disease.
#Diseases that should be reported by the University of Iowa Hygienic Laboratory through the end of calendar year 2002 for purposes of special study.

**Staphylococcus aureus invasive disease
~Streptococcus pneumoniae invasive disease
†Syphilis
Tuberculosis
#Yersinia
(2) Rare diseases:
Anthrax
*Botulism
Brucellosis
*Cholera
Cyclospora
*Diphtheria
Hansen's disease (Leprosy)
Hantavirus syndromes
~Listeria monocytogenes invasive disease
Malaria
Mumps
*Plague
*Poliomyelitis
Psittacosis
Rocky Mountain spotted fever
Rubella (including congenital)
Tetanus
Toxic shock syndrome
Trichinosis
*Yellow fever
~*Vancomycin-resistant Staphylococcus aureus
*Outbreaks of any kind, unusual syndromes, or uncommon diseases
*Diseases or syndromes of any kind caused by a biological agent or toxin when the provider reasonably believes or suspects that the agent or toxin may be a result of a deliberate act such as terrorism. Examples of these agents include *ricin, *tularemia and *smallpox.

b. Specific noncommunicable diseases.

Acute or chronic respiratory conditions due to fumes or vapors or dusts
Asbestosis
Birth defect or genetic disease***
Cancer***
Carbon monoxide poisoning
Coal workers pneumoconiosis
Heavy metal poisoning

*Diseases which are noted with an asterisk should be reported IMMEDIATELY by telephone 1-800-362-2736.
**Numbers of staphylococcal isolates should be reported to the Department of Public Health on a quarterly basis.
~Isolates of organisms from diseases so noted should be sent to the University of Iowa Hygienic Laboratory.
†Sexually transmitted disease.
***NOTE: For these particular diseases, physicians and other health practitioners should not send a report to the department. The State Health Registry of Iowa has been delegated the responsibility for collecting this data through review of records from hospitals, radiation treatment centers, outpatient surgical facilities, oncology clinics, pathology laboratories, and physician offices. Prior to collecting the data from an office or facility, the State Health Registry of Iowa shall work with the office or facility to develop a process for abstracting records which is agreeable to the office or facility.
#Diseases that should be reported by the University of Iowa Hygienic Laboratory through the end of calendar year 2002 for purposes of special study.

Hepatitis, toxic
Hypersensitivity pneumonitis (including farmers lung and toxic organic dust syndrome)
Methemoglobinemia
Pesticide poisoning (including pesticide-related contact dermatitis)
Silicosis
Silo fillers disease
*Diseases or syndromes of any kind caused by a chemical or radiological agent when the provider reasonably believes or suspects that the agent or toxin may be a result of a deliberate act such as terrorism. Examples of these agents include *mustard gas and *sarin gas.

c. Specific occupationally related conditions.
Acute hearing loss and tinnitus
Carpal tunnel and related neuropathy◊
Asthma, bronchitis or respiratory hypersensitivity reactions
Raynaud's phenomenon◊
Severe skin disorder

d. Agriculturally related injuries (work- or non-work-related).

e. Heavy metal poisonings.

(1) Lead poisoning. All analytical values for blood lead analysis shall be reported to the department. Analytical values less than 10 micrograms per deciliter (mg/dL) may be reported as less than 10 micrograms per deciliter (mg/dL) rather than as the actual value. In addition to the analytical value, the following information shall be reported to the department: the date of sample collection, whether the sample is a capillary or venous blood sample, the date of birth and the address of the patient, the name and address of the patient's physician, analytical method used for the analysis, lower quantitation limit of the analytical method, and the quality assurance/quality control values associated with the analysis.

(2) Mercury poisonings.
1. Blood mercury values equal to or greater than 2.8 mcg/dL.
2. Urine mercury values equal to or greater than 20 mcg/L.

(3) Arsenic poisonings.
1. Blood arsenic values equal to or greater than .07 mcg/mL.
2. Urine arsenic values equal to or greater than 100 mcg/L.
3. Twenty-four hour urinary arsenic excretion values equal to or greater than .02 mg/day.

(4) Cadmium poisonings.
1. Blood cadmium values equal to or greater than 5 mcg/L.
2. Urine cadmium values equal to or greater than 10 mcg/L.

(5) Physicians and other health care practitioners are exempted from the requirements of 1.3(1)"*e*" if the laboratory performing the analysis provides the report containing the required information to the department.

*Diseases which are noted with an asterisk should be reported IMMEDIATELY by telephone 1-800-362-2736.
◊NOTE: In the case of employers with more than 200 employees, cases of carpal tunnel syndrome and related neuropathy and Raynaud's phenomenon may be reported semiannually to the department in summary form. Separate semiannual summary reports shall be provided for each physical location where operations are conducted. Such summary reports shall include a separate count of cases of carpal tunnel syndrome and related neuropathy, and Raynaud's phenomenon, by sex and job category.

f. Pesticide poisonings.

(1) Organophosphate and carbamate cholinesterase inhibiting pesticides. In using a given analytic method to measure cholinesterase inhibition, measurement techniques often vary among laboratories. For this reason, when a depressed cholinesterase value is found, in addition to reporting the items specified in rule 641—1.3(139A), each laboratory shall provide to the Iowa department of public health evidence of the rational bases upon which the laboratory identified the reported value as depressed. For example, for nonautomated analytic methods, a laboratory may judge that a cholinesterase value is depressed on the basis of the value falling below two standard deviations from the mean value for tests completed by that laboratory on the general unexposed population. For automated methods, such as automated spectrophotometry, for which there are built-in quality control procedures and appropriate literature for determining normality, the laboratory should judge a value as depressed on the basis of such appropriate literature. In all instances, clinical laboratories shall report any test finding which shows a 25 percent depression in red blood cell, plasma or whole blood cholinesterase from preexposure levels.

(2) Other pesticide poisonings. Any herbicide, organochlorine insecticide or metabolite thereof in a clinical specimen taken from a person with a history of overexposure to such pesticides within the 48 hours previous to collection of the specimen. If a laboratory has no information regarding the exposure history of a person, a report of a positive test finding for a herbicide, organochlorine insecticide or metabolite thereof is not required, but is encouraged to be reported if the levels found are consistent with overexposure.

g. Nitrate poisonings. Blood analyses showing greater than 5 percent of total hemoglobin present as methemoglobin.

h. Toxic hepatitis. In cases where a laboratory has been made aware of a prolonged or possible overexposure to carbon tetrachloride, tetrachloroethane, trichloroethylene, phosphorus, TNT, chloronapthalenes, methylenedianilines, cresol or ethylene dibromide and any abnormal liver tissue biopsy findings which would be attributable to such exposure. If a laboratory has no information on the exposure history of a person, but that person's liver biopsy findings are consistent with exposure to these chemicals, then a laboratory is encouraged, but not required, to report such findings.

i. Noncommunicable respiratory illnesses. Any biopsy of lung tissue indicating prolonged exposure or overexposure to asbestos, silica, silicates, aluminum, graphite, bauxite, beryllium, cotton dust or other textile material, or coal dust.

j. Carbon monoxide (CO) poisoning.

(1) Blood carbon monoxide level equal to or greater than 10 percent carboxyhemoglobin or its equivalent with a breath analyzer test, or

(2) A clinical diagnosis of CO poisoning regardless of any test results.

1.3(2) *Other reportable diseases.* Physicians are required to report any other disease or condition which is unusual in incidence, occurs in unusual numbers or circumstances, or appears to be of public health concern (such as epidemic diarrhea of the newborn in nurseries or a food poisoning episode) including outbreaks of suspected environmental or occupational illness.

641—1.4(139A) Reporting.

1.4(1) *Telephone or other electronic means.*

a. Internationally quarantinable diseases. Any internationally quarantinable disease shall be reported immediately by telephone or other electronic means as soon after the diagnosis as possible. Internationally quarantinable diseases are cholera, plague and yellow fever.

b. Diseases that carry serious consequences or spread rapidly. Any common source epidemic or disease outbreak of unusual numbers or under unusual circumstances should be reported to the department immediately by telephone or other electronic means.

1.4(2) *By mail or other means.* Cases of other reportable diseases and conditions shall be reported to the department by mail at least weekly. If there is concern that delay might hinder the application of organized control measures to protect the public health, the disease or condition should be reported by telephone.

641—1.5(139A) Reporting forms.

1.5(1) Cases of reportable diseases, poisonings and conditions shall be submitted in a format specified by the department.

1.5(2) Sexually transmitted disease/infection should be reported to the department on a sexually transmitted disease/infection form which is provided to health care providers and laboratories. Since these reports are confidential, they shall be transmitted in sealed envelopes or other secure fashion.

1.5(3) Occupational nurses may submit cases of occupationally related reportable diseases or conditions on report forms provided by the department, or may submit copies of either of the following forms:

a. Occupational Safety and Health Act Form No. 101, "Supplementary Record of Occupational Injuries and Illnesses," or

b. State of Iowa Form No. L-1WC-1, "Employers Work Injury Report, Employers First Report of Injury."

Copies of report forms listed in paragraph *"a"* or *"b"* will suffice only if the employer of the occupational nurse has already submitted the original reports to the Iowa industrial commissioner.

641—1.6(139A) Who should report.

1.6(1) Health care providers are required by law to report all cases of reportable diseases attended by them.

1.6(2) Hospitals and other health care facilities are required to report cases of reportable diseases.

1.6(3) School nurses are to report suspected cases of reportable diseases occurring among the children supervised.

1.6(4) School officials, through the principal or superintendent as appropriate, are required to report when there is no school nurse.

1.6(5) Laboratories are required to report cases of reportable diseases and results obtained in the examination of all specimens which yield evidence of or are reactive for sexually transmitted diseases.

1.6(6) Poison control and poison information centers are required to report inquiries about cases of reportable diseases received by them.

1.6(7) Medical examiners are required to report their investigatory finding of any death which was caused by or otherwise involved a reportable disease.

1.6(8) Occupational nurses are required to report cases of reportable diseases, if occupationally related.

641—1.7(139A) Treatment of infant eyes. The Iowa department of public health approves 1 percent silver nitrate solution in single-dose ampules or single-use tubes of an ophthalmic ointment containing 1 percent tetracycline or 0.5 percent erythromycin in each conjunctival sac as an ophthalmia prophylactic for newborn infants' eyes. Prophylaxis should be given after birth, but in no instance delayed for more than one hour after delivery. Once applied, none of the above agents used for prophylaxis shall be flushed from the eyes following installation.

This rule is intended to implement Iowa Code section 139A.38.

641—1.8(139A) Isolation. Isolation and quarantine should be consistent with guidelines provided by the Centers for Disease Control and Prevention, Atlanta, Georgia. (Garner JS, Hospital Infection Control Practices Advisory Committee. Guideline for isolation precautions in hospitals. Infect Control Hosp Epidemiol 1996; 17:53-80, and Am J Infect Control 1996; 24:24-52.)

641—1.9(139A) Quarantine. Quarantine will rarely be imposed by the Iowa department of public health. Should a quarantinable disease occur in Iowa, contacts to the case shall be quarantined as the particular situation requires. Generally, contacts will be tested, as possible, for susceptibility. Immune reactors may be released from quarantine as soon as the laboratory results are available. Susceptible contacts will be continued in quarantine until the longest usual incubation period of the disease has elapsed. Sites of quarantine will be prominently placarded with quarantine signs furnished by the department and posted on all sides of the building wherever access is possible. No susceptible person, not already a contact, will be admitted within the quarantine enclosure.

1.9(1) A person with a communicable disease requiring isolation or quarantine, as demonstrated by the diagnosis of a licensed health care professional or positive laboratory results, shall be confined to an appropriate facility unless the person is attended by a licensed physician and complies with the written orders of the local health department.

1.9(2) A physician who attends a person with a suspected or active communicable disease requiring isolation or quarantine of a type described above, or a clinic giving outpatient treatment to such a person, shall report to the local health department at such times that the local health department requires. The report shall state whether the person is still under treatment, the address of the person, the stage of the disease process, clinical status, and treatment of the disease and the dates and results of laboratory tests or any other information required by the local health department. The physician who attends the person, or the person in charge of a hospital or clinic giving outpatient care to such a person, shall report promptly to the local health department when the person ceases to receive treatment and the reason for the cessation of treatment.

a. A physician who attends a case of active disease of a type reportable pursuant to these rules shall examine or cause all household contacts to be examined. The physician shall promptly report to the local health department the results of said examination. An examination required by this paragraph shall include such tests as may be necessary to diagnose the presence of the disease including, but not limited to, tests to identify specific signs, laboratory examinations, or other diagnostic processes.

b. When required by the local health department, nonhousehold contacts and household contacts not examined by a private physician shall submit to the local health department for a diagnostic test. If any suspicious abnormality is found, steps satisfactory to the local health department shall be taken to refer the person promptly to a physician or appropriate medical facility for further evaluation and, if necessary, treatment. When requested by the local health department, a physician shall report the results of any examination of a contact.

1.9(3) A person with a suspected or active disease that is communicable shall be excluded from attendance at the workplace or school until the person receives the approval of the local health department to attend school or to engage in an occupation or employment. Such person may also be excluded from such premises or facilities as the local health department determines cannot be maintained in a manner adequate to protect others against the spread of the disease.

1.9(4) When the local health department determines that the public health or the health of any other person is endangered by a case of a disease, or a suspected case of a disease, the local health department may, by action commenced by the county attorney, petition the court for orders it deems necessary to protect the public health or the health of any other person. In any court proceeding for appropriate orders, the local health department shall demonstrate the circumstances constituting the necessity for an order. Such orders may include, but shall not be limited, to the following:

a. An order authorizing the removal to, detention in, or both removal to and detention in a hospital or other facility for appropriate examination for disease of a person who has an active disease or who is suspected of having an active disease and who is unable or unwilling to voluntarily submit to such examination by a physician or by the local health department;

b. An order requiring a person who has an active disease to complete an appropriate prescribed course of medication for the disease or, if necessary, to follow required contagion precautions for the disease, which could include self-imposed quarantine;

c. An order requiring a person who has an active disease and who is unwilling otherwise to complete an appropriate prescribed course of medication for the disease to follow a course of directly observed therapy. For the purposes of this provision, "directly observed therapy" shall mean a course of treatment for the disease in which the prescribed medication is administered to and taken by the person under direct observation as specified by the local health department;

d. An order for the removal to, detention in, or both removal to and detention in a hospital or other facility of a person who has an active disease that is communicable or who presents a substantial likelihood of having an active disease that is communicable, based upon epidemiologic evidence, clinical evidence, or laboratory test results; and when the local health department finds, based on recognized infection control principles, that, because of inadequate separation from others, there is a substantial likelihood such person may transmit the disease to others; and

e. An order for the removal to, detention in, or both removal to and detention in a hospital or other facility of a person who has an active disease, or who has been reported to the local health department as having an active disease with no subsequent report to the local health department of the completion of an appropriate prescribed course of medication for the disease; and when there is a substantial likelihood, based on the person's past or personal behavior, that the person cannot be relied upon to participate in or to complete an appropriate prescribed course of medication for disease or, if necessary, to follow required contagion precautions for disease. Such behavior may include, but is not limited to, refusal or failure to take medication for treatment of the disease, refusal or failure to complete treatment for the disease, disregard for contagion precautions for the disease, or refusal to comply with self-imposed quarantine.

1.9(5) The local health department, through the county attorney, may seek the immediate removal or detention of a person with an active disease when a judge, upon reviewing the petition and accompanying documentation, finds probable cause to believe that the person has an active disease and, if allowed to remain at liberty, is likely to infect other persons.

a. Within 72 hours after a person's being confined in or transferred to an appropriate facility, a hearing shall be held to determine whether probable cause exists to believe the detained person is at risk of spreading a communicable disease. The hearing may be waived by the respondent. The hearing may be continued upon the request of either party and a showing of good cause, or by the court on its own motion in the due administration of justice, if the respondent is not substantially prejudiced. At the probable cause hearing, the detained person shall have the following rights:

(1) To have been provided with prior notice of the date, time, and location of the probable cause hearing.

(2) To respond to the preliminary finding of probable cause.

(3) To appear in person at the hearing.

(4) To be represented by counsel.

(5) To present evidence on the respondent's own behalf.

(6) To cross-examine witnesses who testify against the respondent.

(7) To view and copy all petitions and reports in the possession of the court.

b. At the hearing, the local health department may rely upon the petition filed under subrule 1.9(4) but may also supplement the petition with additional documentary evidence or live testimony.

c. At the conclusion of the hearing, the court shall enter an order which does both of the following:

(1) Verifies the respondent's identity.

(2) Determines whether probable cause exists to believe that the respondent is at risk of transmitting a communicable disease.

d. If the court determines that probable cause does exist, the court shall direct that the respondent be transferred to an appropriate facility for an evaluation as to whether the respondent is at risk of transmitting a communicable disease. The evaluation shall be conducted by a person deemed to be professionally qualified to conduct such an examination.

e. Notwithstanding the foregoing emergency provisions, in no event shall any person be detained for more than 90 days without a further hearing or court order authorizing such continued detention. The local health department shall seek further court review of such detention within 90 days following the initial court order authorizing detention and thereafter within 90 days of each subsequent court review. In all court proceedings for removal or detention of a person issued pursuant to this rule, or for review of the continued detention of a person, the local health department shall prove the circumstances constituting the necessity for such detention by clear and convincing evidence.

f. Except under the circumstances of an emergency removal or detention, any person who is subject to a detention order shall have the right to be represented by counsel. Upon the request of such person, counsel shall be provided by the court.

1.9(6) Content of petition.

a. Any petition for orders pursuant to paragraph 1.9(4)*"d"* or 1.9(4)*"e"* shall set forth the following:

(1) The legal authority under which the order is requested, including a reference to these rules or other law or regulation;

(2) An individualized assessment of the person's circumstances, behavior, or both, constituting the basis for the issuance of such orders;

(3) The less restrictive treatment alternatives that were attempted and were unsuccessful or the less restrictive treatment alternatives that were considered and rejected, and the reasons such alternatives were rejected.

b. In addition, any request for an order for the removal and detention of a person shall:

(1) Include the purpose of the detention;

(2) Advise the person being detained of the right to a further hearing regarding the person's release from detention and that, in any event, the detention shall not continue for more than three business days in the absence of a hearing and a court order authorizing such detention;

(3) Advise the person being detained of the right to arrange to be represented by counsel or to have counsel provided and that, if the person chooses to have counsel provided, such counsel will be notified that the person has requested legal representation.

1.9(7) Notwithstanding any inconsistent provision of this rule:

a. A person who is detained solely pursuant to paragraph 1.9(4)*"d"* shall not continue to be detained beyond the minimum period of time required, with the exercise of all due diligence, to make a medical determination of whether a person who is suspected of having a disease has an active disease or whether a person has an active disease which is communicable. Further detention of such person shall be authorized only upon the issuance of a court order pursuant to the above procedures.

b. A person who is detained pursuant to these rules shall not continue to be detained after the person's disease ceases to be communicable or after the local health department ascertains that changed circumstances exist that permit the person to be adequately separated from others so as to prevent transmission of disease after the person's release from detention.

c. A person who is detained pursuant to these rules shall not continue to be detained after the person's disease is no longer communicable and the person has agreed to comply with prescribed medical care.

1.9(8) When necessary, language interpreters and persons skilled in communicating with vision-impaired and hearing-impaired persons shall be provided in accordance with applicable law.

1.9(9) These rules shall not be construed to permit or require the forcible administration of any medication without a prior court order.

1.9(10) For the purposes of these rules, a person has an active disease when (1) a laboratory test is positive for the disease and the person has not completed an appropriate prescribed course of medication for the disease, or (2) physical examination by a licensed health care provider has resulted in a diagnosis of an active disease. A person who has an active disease shall be considered capable of transmitting this disease until a licensed health care professional determines that the disease is no longer communicable.

641—1.10(139A) Disinfection. Disinfection should be consistent with guidelines provided by the Centers for Disease Control and Prevention, Public Health Service, U.S. Department of Health and Human Services, Atlanta, Georgia. (Garner JS, Hospital Infection Control Practices Advisory Commitee. Guideline for isolation precautions in hospitals. Infect Control Hosp Epidemiol 1996; 17:53-80, and Am J Infect Control 1996; 24:24-52.)

641—1.11(141A) Contagious or infectious disease notification at time of death. The purpose of this rule is to establish contagious or infectious disease notification requirements for the information of any person handling a dead body.

1.11(1) A health care provider attending a person prior to the person's death shall, at the time of death, place with the body a written notice which specifies or signifies either "known contagious or infectious disease" or "suspected contagious or infectious disease."

1.11(2) The health facility in which the health care provider is working shall be responsible for establishing written procedures and implementing the specific internal practices necessary to satisfy this notification requirement.

These rules are intended to implement Iowa Code sections 135.100 to 135.103, 139A.2, 139A.3, 139A.21, 139A.31, 139A.37, 141A.1, 141A.2 and 141A.5.

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CHAPTER 2
OPHTHALMIA PROPHYLACTICS
Rescinded IAB 5/30/01, effective 7/4/01

CHAPTER 3
CLINICAL LABORATORIES
Rescinded IAB 5/30/01, effective 7/4/01

◊Two ARCs

CHAPTER 5
MATERNAL DEATHS
[Prior to 7/29/87, Health Department[470]]

641—5.1(135) Reporting of maternal deaths. A maternal death is any death occurring while a woman is pregnant or of a woman within one year after delivery. This includes but is not limited to deaths resulting from abortions, ectopic pregnancies and all deaths during pregnancy, childbirth, puerperium or deaths from complications of childbirth. In the event of a maternal death, the certifying physician shall indicate that circumstance on the certificate of death.

641—5.2(135) Ascertainment of maternal deaths. The department of public health annually shall systematically ascertain maternal deaths using birth and death vital records.

641—5.3(135) Reviewing of maternal deaths. Hospitals, physicians, and other licensed health care professionals shall provide to the department of public health clinical records pertinent to the review of individual maternal deaths. The release of these materials is a confidential and privileged communication, and no liability shall be attached to the release. Neither the released information nor reports generated from that information shall be allowed in any legal proceedings, pursuant to Iowa Code section 135.42. The department of public health shall ensure a timely, confidential review of all maternal deaths by experts in obstetric medicine and maternal mortality for the purpose of reducing morbidity and mortality. At least every three years, the department shall issue occasional reports on the causes and contributing factors of maternal deaths and recommendations of possible preventive strategies based on those reviews.

These rules are intended to implement Iowa Code section 135.40.

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CHAPTER 126
STATE MEDICAL EXAMINER

[Prior to 4/20/88, see Medical Examiner, State[566] Ch 1]
[Prior to 7/1/99, see Public Safety Department[661] Ch 21]

641—126.1(691) Autopsies for sudden infant deaths—reimbursement. Rescinded IAB 12/12/01, effective 1/16/02.

641—126.2(691) Medical examiner coverage. Rescinded IAB 12/12/01, effective 1/16/02.

641—126.3(691) Fees for autopsies and related services and reimbursement for related expenses. Autopsies performed by the state medical examiner division are provided on a fee-for-service basis. Costs of autopsies and related services and expenses are the responsibility of the county of residence of the deceased when requested by a public agency and of the person requesting the autopsy when the request is made by a private party. The estate of the deceased shall be responsible for payment of these fees and expenses when the request for an autopsy is made by the executor of the estate on behalf of the estate.

126.3(1) *Fee schedule.* The following fees shall apply to autopsies conducted by the state medical examiner division:

Autopsy	$1000
Copies of reports	$ 20

EXCEPTIONS: A copy of the autopsy report is included in the autopsy fee. A single copy of an autopsy report may be provided to a family member of the deceased without fee. Copies of autopsy reports may be provided to public officials for official purposes without fee.

126.3(2) *Expense reimbursement.* Other laboratory services associated with an autopsy, which shall include, but not be limited to, photography, toxicology, radiology, microbiology, and morgue fees, shall be billed by the department to the county of residence of the deceased or to the private individual requesting the autopsy at the cost to the department of the service. Moneys collected pursuant to this subrule shall be paid by the department to the laboratory or other entity providing the service.

126.3(3) *State medical examiner acting as county medical examiner.* When the state medical examiner acts in the capacity of county medical examiner, the state medical examiner shall receive from the county of appointment a fee of $100 per hour, with a one-hour minimum, for each report prepared plus the state medical examiner's actual expenses. Counties may not depend on the state medical examiner for full-time coverage.

This rule is intended to implement Iowa Code section 691.6.

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CHAPTER 127
COUNTY MEDICAL EXAMINERS
[Prior to 7/29/87, Health Department [470] Ch 127]

641—127.1(144,331,691) Definitions.

"Autopsy" means the external and internal postmortem examination of a deceased person.

"Cause of death" means the disease or injury which sets in motion the chain of events which eventually result in the death of a person. The physician shall consider "but for" this injury or disease the person would still be living.

"County medical examiner" or *"CME"* means a medical or osteopathic physician or surgeon licensed in the state of Iowa and appointed by the board of supervisors to serve in this capacity.

"County medical examiner investigator" or *"CME-I"* means an individual appointed by a county medical examiner, with approval by the board of supervisors and the state medical examiner, to serve under the supervision of a county medical examiner to assist in death investigations.

"County of appointment" means the county which requests a medical examiner to conduct an investigation, perform or order an autopsy, or prepare a report(s) in a death investigation case. The request may be authorized by the county attorney or the county medical examiner. The county of appointment shall be the county in which the death occurred.

"Cremation" means the technical process, using heat and flame, that reduces human remains to bone fragments.

"Day" means calendar day.

"Death" means the condition as described in Iowa Code section 702.8.

"Death affecting the public interest" means any death of a human being in which the circumstances are sudden, unexpected, violent, suspicious, or unattended, including but not limited to those deaths listed at Iowa Code section 331.802(3) and described as follows:

1. Violent death. Violent death includes homicide, suicide, or accidental death resulting from physical, mechanical, thermal, chemical, electrical, or radiation injury. A medical examiner's investigation and report are required irrespective of the period of survival following injury.
2. Death caused by criminal abortion, including self-induced.
3. Death related to disease thought to be virulent or contagious which may constitute a public hazard. Any such case investigated by a medical examiner shall be reported to the department and to the local health authority.
4. Death that has occurred unexpectedly or from an unexplained cause. This term includes the following situations:

- Death without prior medical conditions accounting for the death.
- Apparently instantaneous death without obvious cause.
- Death during or following an unexplained syncope or coma.
- Death during an unexplained, acute, or rapidly fatal illness.

5. Death of a person confined in a prison, jail, or correctional institution.
6. Death of a person when unattended by a physician during the period of 36 hours immediately preceding death.

- This term includes the following situations:

— Persons found dead without obvious or probable cause.
— Death when the person was unattended by a physician during a terminal illness.
— Fetal death unattended by a physician. A fetal death is a fetus born dead within its twentieth week of gestation or a fetus which weighs 350 grams or more (Iowa Code section 144.29).

• This term does not include a prediagnosed terminal or bedfast case in which a physician has been in attendance within 30 days preceding the death.

• This term does not include a terminally ill patient who was admitted to and received services from a hospice program as defined in Iowa Code section 135J.1, if a physician or registered nurse employed by the program was in attendance within 30 days preceding the death.

7. Death of a person if the body is not claimed by a relative or friend.

8. Death of a person if the identity of the deceased is unknown.

9. Death of a child under the age of two years if death results from an unknown cause or if the circumstances surrounding the death indicate that sudden infant death syndrome may be the cause of death.

"Department" means the Iowa department of public health.

"Deputy county medical examiner" or *"DCME"* means an individual appointed by a county medical examiner, with approval by the board of supervisors and the state medical examiner, to assist the county medical examiner in the performance of the county medical examiner's duties.

"External examination" means a close inspection of the exterior of a deceased human body for the purpose of locating, describing, and delineating any and all injuries or other abnormalities. External examination of a body does not constitute an autopsy, even if toxicology samples are obtained.

"Fee" means an amount to be paid to a county medical examiner's office as determined by the board of supervisors of the county of appointment for completion of an investigation, autopsy, or report(s). Fees for services provided by the state medical examiner's office are established at 641—126.3(691).

"Form ME-1" means the Preliminary Report of Investigation by Medical Examiner form.

"Form ME-2" means the Medical Examiner Embalming Certificate form.

"Form ME-3" means the Permit by Medical Examiner for Autopsy form.

"Form ME-4" means the Preliminary Report of Child/Infant Death Scene Investigation form.

"Form ME-5" means the Cremation Permit by Medical Examiner form.

"Form ME-6" means the Iowa State Medical Examiner's Office Personal Effects form.

"Form ME-7" means the Medication List form.

"Form ME-8" means the Body Identification Record form.

"Manner of death" means the circumstances under which the cause of death occurred and may be specified as follows: natural, accident, suicide, homicide, undetermined, or pending.

"Medical care provider" means an individual licensed or certified in any medical profession, including but not limited to a physician, physician assistant, nurse, emergency medical care provider, certified nurse's aide, pharmacist, physical therapist, and medical technologist.

"Medical examiner" means the state medical examiner, deputy state medical examiner, county medical examiner, or deputy county medical examiner.

641—127.2(331,691) Duties of medical examiners—jurisdiction over deaths which affect the public interest.

127.2(1) *Jurisdiction.* Upon receiving notification of a death which affects the public interest, a medical examiner shall notify any appropriate law enforcement agency not otherwise notified and shall take charge of the body of the decedent. The body shall not be disturbed or removed from the position in which it was found without authorization from the medical examiner except for the purpose of preserving the body from loss or destruction or permitting the passage of traffic on a highway, railroad, or airport, or unless the failure to remove the body might endanger life, safety, or health.

127.2(2) *Investigation.* A county medical examiner shall conduct a preliminary investigation of the cause and manner of death and shall utilize the investigative protocol outlined in the most current edition of the County Medical Examiner's Handbook, available from the state medical examiner's office. A medical examiner may perform or authorize performance of any scientific study to assist in identifying the cause, circumstances, and manner of death. A medical examiner shall cooperate with other investigating officials and agencies involved and shall share reports, information, and conclusions with these officials and agencies.

127.2(3) *Report—Form ME-1.*

a. Preparation and filing. A county medical examiner shall prepare a written report of the examiner's findings on the Preliminary Report of Investigation by Medical Examiner, Form ME-1. A county medical examiner shall file the original Form ME-1 with the state medical examiner's office within 14 days of the date of death and shall file a copy of the Form ME-1 with the county attorney within 14 days of the date of the death and shall retain a copy for the medical examiner's records.

b. Content. Form ME-1 shall be completed as fully as possible in light of all available information and may be signed by either a county medical examiner or a county medical examiner investigator acting under the supervision of a county medical examiner. If the cause or manner of death, identity of the decedent, or other information is unknown or pending at the time of filing, "unknown" or "pending" may be written in the appropriate area of the form. If additional information becomes available, this information shall be forwarded to the state medical examiner in written form at such time as it becomes available to be added as a supplement to the file.

127.2(4) *Disposition of body.* After an investigation, including an autopsy if one was performed, the body of the decedent shall be made available to the funeral home designated by a relative or friend of the decedent for burial or appropriate disposition. A medical examiner shall not use influence in favor of a particular funeral director or funeral home. If no one claims a body, it shall be disposed of as provided in Iowa Code chapter 142.

127.2(5) *Coverage.*

a. When an individual is required to report a death to a medical examiner and the county medical examiner cannot be located or is not available, the individual shall contact a county medical examiner from any adjacent Iowa county to perform those duties outlined in this chapter. The responding medical examiner shall have full authority to conduct any procedures necessary to the investigation of the cause and manner of death. If an adjacent county medical examiner is not available, the state medical examiner shall be contacted and may act in the capacity of a county medical examiner.

b. The responding county medical examiner shall be reimbursed by the county for which the service is provided for all fees and expenses at the rate which is customarily paid by the county for which the service is provided or at a rate agreed upon by the medical examiner and the board of supervisors of the county for which the service is provided.

641—127.3(331,691) Autopsies.

127.3(1) *Autopsy required.* A county medical examiner shall perform an autopsy or order that an autopsy be performed in the following cases:

a. All cases of homicide or suspected homicide, irrespective of the period of survival following injury.

b. All cases in which the manner of death is undetermined.

c. All cases involving unidentified bodies.

d. All deaths of children under the age of two when there is not a clear cause of death, including suspected cases of sudden infant death syndrome. A summary of the findings of the autopsy shall be transmitted by the physician who performed the autopsy to the county medical examiner within two days of completion of the report. Autopsies performed on children under the age of two when the circumstances surrounding the death indicate that sudden infant death syndrome may be the cause of death or the cause of death is not clearly explained by known medical history shall conform to Form ME-4.

127.3(2) *Autopsy recommended.* A county medical examiner should perform an autopsy or order that an autopsy be performed in the following cases:

a. Deaths of adolescents less than 18 years of age when there is not a natural cause of death.

b. All cases which involve a motor vehicle crash, unless it is a single motor vehicle accident with no potential for litigation and there is an obvious cause of death or the injuries have been clearly documented by hospitalization.

c. Drowning deaths.

d. Deaths in a prison, jail, correctional institution, or mental health institute, or under police custody, where there is not a natural disease process which accounts for the death.

e. Deaths from suicide.

f. All pedestrian, bicyclist, motorcycle, snowmobile, three-wheeler or all-terrain vehicle fatalities.

g. Deaths due to failure of a consumer product.

h. Deaths due to a possible public health hazard.

i. Deaths due to drug or alcohol abuse or overdose.

j. Deaths due to poisoning.

k. Deaths of airplane pilots who die as a result of an airplane crash. The National Transportation Safety Board and the Federal Aviation Administration should be contacted prior to the autopsy to request specimen collection kit(s).

l. Electrical- and lightning-related deaths.

m. Deaths from burns or smoke or soot inhalation.

n. Deaths due to a natural disaster, including tornadoes and floods.

o. All farm- and work-related deaths unless there is an obvious natural cause of death.

p. All deaths related to exposure, such as hypothermia and hyperthermia.

q. All sport-related deaths, including deaths from auto racing and deaths resulting from injuries sustained in football, basketball, soccer, or other games or sports.

127.3(3) *Other deaths.* For those deaths not listed in subrule 127.3(1) or 127.3(2), a county medical examiner shall determine whether the public interest requires an autopsy and may perform an autopsy or order that an autopsy be performed. A county medical examiner may consult with the state medical examiner to assist in determining the need for an autopsy.

127.3(4) *Performance of autopsy.*

a. Who may authorize. Autopsies may be authorized by the state medical examiner, the county medical examiner for the county in which the death occurred or the county where any injury contributing to or causing the death was sustained, or the county attorney who would have jurisdiction in any criminal proceeding related to the death.

b. Who may perform. An autopsy shall be performed by a pathologist trained or with experience in forensic pathology, licensed to practice medicine and surgery or osteopathic medicine and surgery in the state of Iowa and board-certified by the American Board of Pathology, or under the direct supervision of a physician with these qualifications. If an autopsy is performed by a physician who does not satisfy these criteria and who is not performing under the direct supervision of a physician who satisfies these criteria, the physician shall submit a supplemental report with the Permit by Medical Examiner for Autopsy, Form ME-3, which details the specific training, education, and experience which qualify the physician to perform an autopsy.

c. Permit required—Form ME-3. A medical examiner shall complete the Permit by Medical Examiner for Autopsy, Form ME-3. All reasonable efforts shall be made to complete the Form ME-3 prior to the performance of an autopsy and to submit the form with the body of the decedent or to submit the form via facsimile to the state medical examiner.

127.3(5) *Autopsy report.* A complete record of the findings of the autopsy shall be submitted to the state medical examiner's office, the county attorney of the county where the death occurred and the county attorney of the county where the injury contributing to or causing the death was sustained within 90 days following the date of death, unless unusual circumstances requiring further investigation or testing exist. The report filed shall include all diagrams, transcriptions of the autopsy observations and opinions, and toxicology reports.

127.3(6) *Out-of-state autopsy.* The body of a decedent may be sent out of state for an autopsy or postmortem examination only if the county medical examiner certifies in writing that the out-of-state autopsy or examination is necessary for any of the following reasons:

a. A forensic pathologist practicing in the state of Iowa is unavailable;

b. Requiring an in-state autopsy would cause financial hardship; or

c. Requiring an in-state autopsy would delay the funeral or burial more than three days.

641—127.4(331,691) Fees.

127.4(1) *Payment of fee and expenses.*

a. A medical examiner shall receive from the county of appointment a fee for each preliminary investigation and report submitted in a case in which a death affects the public interest. A county medical examiner shall also receive from the county of appointment the examiner's actual expenses.

b. A pathologist or other physician who performs an autopsy under medical examiner authorization shall be paid for the services by the county of appointment.

127.4(2) *Reimbursement.*

a. County of residence different from county of appointment—Iowa resident. The county of the decedent's residence shall reimburse the county of appointment for the fee and expenses paid by the county of appointment.

b. Death caused by criminal defendant. If the person's death is caused by a criminal defendant who has been convicted and sentenced for murder, voluntary manslaughter, involuntary manslaughter, or homicide by vehicle, the county of the person's residence may recover from the defendant the fee and expenses.

c. Out-of-state resident—law enforcement involvement. The fee and expenses of a county medical examiner who performs an investigation or autopsy of a person who dies after being brought into the state for emergency medical treatment by or at the direction of an out-of-state law enforcement officer or public authority shall be paid by the state. A claim for payment shall be filed with the department.

d. Out-of-state resident—no law enforcement involvement. The fee and expenses of a county medical examiner who performs an investigation or autopsy of an out-of-state resident shall be paid by the county of appointment.

e. Child under the age of two. If the death of a child under the age of two results from an unknown cause or if the circumstances surrounding the death indicate that sudden infant death syndrome may be the cause of death, the department shall reimburse the county of appointment up to $400 toward the expense of the autopsy. A county auditor may submit a copy of the bill and the autopsy report to Iowa SIDS Program, Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319. A request for reimbursement shall be submitted within one year after the date of death.

641—127.5(144,331,691) Death certificates—deaths affecting the public interest.

127.5(1) *Completion.* The funeral director to whom the body is released shall complete the personal data on the death certificate. The medical examiner shall complete the manner of death and cause of death sections of the death certificate within 24 hours after taking charge of the case. If an autopsy is performed by the state medical examiner, the death certificate shall be submitted to the state medical examiner's office for completion. All information included on the certificate shall be typewritten.

127.5(2) *Filing.* The funeral director shall file the certificate with the county registrar in the county in which the death occurred. A death certificate shall be filed prior to the issuance of a burial transit permit and prior to disposal of the body.

127.5(3) *Extension of time.* If a medical examiner is unable to complete the manner of death and cause of death sections of the death certificate within the 24-hour time period, the funeral director shall file a death certificate form completed with all available information. Such certificate shall be authority for the issuance of a burial transit permit. Within 15 days, a supplemental report shall be filed with the local registrar which provides the information missing from the original certificate.

127.5(4) *Additional standards.* Additional rules relative to death certificates may be found at 641—Chapter 101.

641—127.6(331,691) Cremation.

127.6(1) *Permit obtained prior to cremation—Form ME-5.* A permit for cremation shall be obtained from a county medical examiner prior to cremation of a body of a decedent. For purposes of this requirement, a facsimile or electronic copy of the cremation permit has the same legal effect as the original. Cremation permits shall be issued on the Cremation Permit by Medical Examiner, Form ME-5.

127.6(2) *Requirements for issuance of permit.* A county medical examiner shall direct an inquiry into the cause and manner of death and shall determine whether the death is one which affects the public interest prior to issuing a cremation permit.

a. Death which affects the public interest. If the death occurred in a manner specified in Iowa Code section 331.802(3) or if reasonable suspicion that the death occurred in such a manner exists, a medical examiner shall view the body, make a personal inquiry into the cause and manner of death, and complete or cause to be completed all necessary autopsy or postmortem examinations prior to issuing a cremation permit.

b. Death which does not affect the public interest. If, following an inquiry into the cause and manner of death, the county medical examiner determines that the death did not occur in a manner specified in Iowa Code section 331.802(3), a medical examiner is not required to view the body prior to issuing a cremation permit. A county medical examiner shall certify on the Cremation Permit by Medical Examiner, Form ME-5, that the medical examiner's inquiry into the cause and manner of death did not disclose evidence that the death occurred in a manner specified in Iowa Code section 331.802(3).

127.6(3) *Fee.* A fee for the Cremation Permit by Medical Examiner, Form ME-5, shall be paid by the family, next of kin, guardian of the decedent, or other person authorized to act on behalf of the decedent.

641—127.7(331,691) County medical examiner investigators.

127.7(1) *Appointment.* A county medical examiner may appoint one or more county medical examiner investigators upon approval by the board of supervisors and the state medical examiner.

127.7(2) *Qualifications.*

a. Prior to appointment, a CME-I shall possess a minimum of two years of experience as a licensed or certified nurse or medical care provider; and

b. Prior to or within three years of appointment, a CME-I shall satisfy the following criteria:

(1) Attend the St. Louis School of Medicine Medicolegal, Basic and Master's Death Investigation Course or its state medical examiner-approved equivalent; and

(2) Obtain and maintain certification as a death investigator by the National Association of Medical Examiners.

c. A CME-I is not required to meet the requirements of paragraph *"a"* or *"b"* if the individual has functioned in the capacity of a CME-I for a period of five years as of January 1, 2002.

d. If a CME is unable to appoint a CME-I who possesses the qualifications required by paragraph *"a," "b,"* or *"c,"* the CME may request a waiver. Waiver requests shall be submitted in writing to the state medical examiner and shall include the efforts undertaken by the CME to locate a CME-I who meets the above qualifications; the qualifications of the individual willing to serve in the capacity of CME-I; and the period of time for which the waiver is requested, not to exceed two years. The state medical examiner has sole discretion to waive the requirements of this rule and may withdraw or modify a waiver request upon a finding that the CME-I has failed to adequately perform the duties of the position or for other good cause.

127.7(3) *Duties.* A CME-I shall assist in death investigations. A CME-I acting under the supervision of a county medical examiner may sign the Form ME-1. A CME-I shall not sign a certificate of death or a Form ME-5.

127.7(4) *Supervision.* A CME-I shall serve under the supervision of a county medical examiner. A CME-I may provide services only when in the personal presence of a county medical examiner or under the direction of a county medical examiner who is available in person or under the direction of a county medical examiner when the county medical examiner or the state medical examiner's office is available by telephonic communication. A CME-I shall at all times perform services in a manner which is consistent with the protocol outlined in the most current edition of the County Medical Examiner's Handbook and any policies or protocols of the supervising county medical examiner.

127.7(5) *Fees.* Fees for the services provided by a CME-I shall be paid by the county of appointment.

641—127.8(331,691) Deputy county medical examiners.

127.8(1) *Appointment.* A county medical examiner may appoint one or more deputy county medical examiners upon approval by the board of supervisors and the state medical examiner.

127.8(2) *Qualifications.* A DCME shall be licensed in the state of Iowa as a medical or osteopathic physician or surgeon.

127.8(3) *Duties.* A DCME shall serve at the direction of the county medical examiner and may perform any duty of a county medical examiner which is delegated by the county medical examiner to the DCME.

127.8(4) *Fees.* Fees for the services provided by a DCME shall be paid by the county of appointment.

641—127.9(331,691) Failure to comply with rules. If a county medical examiner, deputy county medical examiner, county medical examiner investigator, pathologist, or other physician fails to comply with these rules, the state medical examiner may provide written notice of the failure to comply to that individual, the appropriate county medical examiner, and the appropriate county board of supervisors. Within 30 days of the date of the notice, the individual to whom the notice was provided shall submit a written response to the state medical examiner, outlining a proposed corrective action plan. If no response is received within the 30 days or if the proposed corrective action plan is unacceptable, the state medical examiner shall forward copies of the notice and all pertinent correspondence and information to the board of supervisors for the county which appointed the individual, notifying the board of the individual's failure to comply with these rules.

641—127.10(331,691,22) Confidentiality. Records and reports of a medical examiner may be confidential records pursuant to Iowa Code sections 22.7(2), 22.7(5), and 22.7(41) and other provisions of Iowa law. Prior to releasing a medical examiner record or report to a member of the public, a county medical examiner may inform the appropriate law enforcement agency, the county attorney, and the state medical examiner to determine whether release is authorized under Iowa law.

641—127.11(331,691,670) Indemnification. A board of supervisors shall defend, hold harmless, and indemnify a county medical examiner and any properly appointed staff members to the extent provided in Iowa Code chapter 670.

These rules are intended to implement Iowa Code chapters 331 and 691.

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CHAPTER 174
AGENCY PROCEDURE FOR RULE MAKING

The department of public health adopts the agency procedure for rule making segment of the Uniform Administrative Rules which is printed in the first volume of the Iowa Administrative Code with the following amendments.

641—174.3(17A) Public rule-making docket.

174.3(2) *Anticipated rule making.* In lieu of the words "(commission, board, council, director)" insert "director".

641—174.4(17A) Notice of proposed rule making.

174.4(3) *Notices mailed.* In lieu of the words "(specify time period)" insert "one calendar year".

641—174.5(17A) Public participation.

174.5(1) *Written comments.* In lieu of the words "(identify office and address) or" insert "Director's Office, Iowa Department of Public Health, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319".

174.5(5) *Accessibility.* In lieu of the words "(designate office and telephone number)" insert "Director's Office, Iowa Department of Public Health, (515)281-7689".

641—174.6(17A) Regulatory flexibility analysis.

174.6(3) *Mailing list.* In lieu of the words "(designate office)" insert "Director's Office, Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319".

641—174.11(17A) Concise statement of reasons.

174.11(1) *General.* In lieu of the words "(specify the office and address)" insert "Director's Office, Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319".

641—174.13(17A) Agency rule-making record.

174.13(2) *Contents.* Amend paragraph *"c"* by inserting "director" in lieu of "(agency head)".

These rules are intended to implement Iowa Code section 17A.4 and Iowa Code chapter 135.

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875—1.55(17A) Service and filing of petitions and other papers.

1.55(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 all other persons identified in the petition for declaratory order or petition for intervention as affected by or interested in the questions presented, simultaneously with their filing. The party filing a document is responsible for service on all parties and other affected or interested persons.

1.55(2) *Filing—when required.* All petitions for declaratory orders, petitions for intervention, briefs, or other papers in a proceeding for a declaratory order shall be filed with the Declaratory Orders Coordinator, Division of Labor Services, 1000 East Grand Avenue, Des Moines, Iowa 50319. All petitions, briefs, or other papers that are required to be served upon a party shall be filed simultaneously with the division.

1.55(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 rule 875—1.75(17A).

875—1.56(17A) Consideration. Upon request by petitioner, the division shall schedule a brief and informal meeting between the original petitioner, all intervenors, or a member of the staff of the division, to discuss the questions raised. The division may solicit comments from any person on the questions raised. Also, comments on the questions raised may be submitted to the division by any person.

875—1.57(17A) Action on petition.

1.57(1) Within the time allowed by 1998 Iowa Acts, chapter 1202, section 13(5), after receipt of a petition for a declaratory order, the labor commissioner or designee shall take action on the petition as required by 1998 Iowa Acts, chapter 1202, section 13(5).

1.57(2) The date of issuance of an order or of a refusal to issue an order is as defined in rule 875—1.66(17A).

875—1.58(17A) Refusal to issue order.

1.58(1) The division 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 questions raised for the following reasons:

1. The petition does not substantially comply with the required form.
2. The petition does not contain facts sufficient to demonstrate that the petitioner will be aggrieved or adversely affected by the failure of the division to issue an order.
3. The division 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 division 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 a division decision already made.

9. The petition requests a declaratory order that would necessarily determine the legal rights, duties, or responsibilities of other persons who have not joined in the petition, intervened separately, or filed a similar petition and whose position on the questions presented may fairly be presumed to be adverse to that of petitioner.

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

1.58(2) A refusal to issue a declaratory order must indicate the specific grounds for the refusal and constitutes final agency action on the petition.

1.58(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 a ruling.

875—1.59(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 petitioner and all intervenors, the specific statutes, rules, policies, decisions, or orders involved, the particular facts upon which it is based, and the reasons for its conclusion.

A declaratory order is effective on the date of issuance.

875—1.60(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.

875—1.61(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 division, 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 division. The issuance of a declaratory order constitutes final agency action on the petition.

875—1.62 to **1.64** Reserved.

DIVISION V
CONTESTED CASES

875—1.65(17A) Scope and applicability. This division applies to contested case proceedings conducted by the division of labor services. Rules of the employment appeal board are applicable for some contested cases regarding boiler safety, elevator safety, and occupational safety and health inspections and contractor registration investigations.

875—1.66(17A) Definitions. Except where otherwise specifically defined by law:

"Contested case" means a proceeding defined by Iowa Code section 17A.2(5) and includes a no factual dispute contested case under 1998 Iowa Acts, chapter 1202, section 14.

"Issuance" means the date of mailing of a decision or order or date of delivery if service is by other means unless another date is specified in the order.

"Party" means each person or agency named or admitted as a party or properly seeking and entitled as of right to be admitted as a party.

"Presiding officer" means the labor commissioner or designee.

"Proposed decision" means the presiding officer's recommended findings of fact, conclusions of law, decision, and order in a contested case in which the division of labor services did not preside.

1.102(6) The name, address, and telephone number of any public agency or political subdivision which also regulates the activity in question or which might be affected by the grant of a waiver or variance.

1.102(7) Any information known to the petitioner regarding the division's treatment of similar cases.

1.102(8) The name, address, and telephone number of all persons inside or outside state government who would be adversely affected by the grant of the petition or who possess knowledge of relevant facts.

1.102(9) A signed release of information authorizing persons with knowledge regarding the request to furnish the division with information pertaining to the waiver or variance.

1.102(10) A signed statement from the petitioner attesting to the accuracy of the facts provided in the petition.

875—1.103(17A,91) Notice and acknowledgment. The division will acknowledge petitions upon receipt. The division shall ensure that notice of the pendency of the petition and a concise summary of its contents have been provided to all persons to whom notice is required by any provision of law within 30 days of receipt of the petition. The division may require the petitioner to serve the notice and a concise summary on all persons to whom notice is required by any provision of law, and provide a written statement to the division attesting that notice has been provided. Notice and a concise summary may also be provided to others.

875—1.104(17A,91) Review. Each petition for a waiver or variance shall be evaluated by the agency based on the unique, individual circumstances set out in the petition. Discretion to grant or deny a waiver or variance petition rests with the labor commissioner or the labor commissioner's designee. The burden of persuasion shall be upon the petitioner. The division may request additional information relating to the requested waiver or variance from the petitioner and may conduct any necessary and appropriate investigation.

1.104(1) A waiver or variance may be granted if the division finds all of the following based on clear and convincing evidence:

a. Application of the rule would pose an undue hardship on the person for whom the waiver or variance is requested;

b. The provisions of a rule subject to a petition for a waiver or variance are not specifically mandated by statute or another provision of law;

c. Waiver or variance of the rule in the specific circumstances would not prejudice the substantial legal rights of any person or cause a denial of federal funds; and

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

1.104(2) Petitioners requesting permanent waivers or variances must also show that a temporary waiver or variance would be impracticable.

875—1.105(17A,91) Ruling.

1.105(1) The division shall grant or deny all requests as soon as practicable, but no later than 120 days from receipt without consent of the petitioner. However, waiver or variance petitions filed in contested cases shall be granted or denied no later than the date of the decision in the contested case proceeding. Failure to grant or deny a petition within the required time period shall be deemed a denial.

1.105(2) If a waiver or variance is granted, it shall be drafted to provide the narrowest exception possible to the provisions of the rule. The ruling shall be in writing and shall include the reasons for granting or denying the petition and, if approved, the time period during which the waiver or variance is effective. The division may place any condition on a waiver or variance that the division finds desirable to protect the public health, safety, and welfare.

1.105(3) Within seven days of issuance of the ruling, a copy shall be mailed to the petitioner or the petitioner's representative, and to any other person(s) entitled to such notice by any provision of law or rule.

875—1.106(17A,91) Public availability. Subject to the provisions of Iowa Code section 17A.3(1)*"e,"* orders granting and denying waivers or variances shall be indexed by rule and available for public inspection.

875—1.107(17A,91) Cancellation. The division may cancel a waiver or variance upon appropriate notice and hearing if the facts alleged in the petition or supplemental information provided were not true, material facts were withheld or have changed, the alternative means of compliance provided in the waiver or variance have failed to achieve the objectives of the statute, the requester has failed to comply with conditions set forth in the waiver or variance approval, or the rule or enabling Act has been amended.

875—1.108(17A,91) Violations. Violation of conditions in the waiver or variance approval is the equivalent of violation of the particular rule for which the waiver or variance is granted and is subject to the same remedies or penalties.

875—1.109(17A,91) Appeals. Appeal from a decision granting or denying a waiver or variance shall be in accordance with the procedures provided in Iowa Code chapter 17A. An appeal shall be taken within 30 days of the ruling. However, any appeal from a decision on a petition for waiver or variance in a contested case proceeding shall be in accordance with the procedures for appeal of the contested case decision.

These rules are intended to implement Iowa Code chapters 17A, 22 and 91, 2000 Iowa Acts, House File 2206, and Executive Order Number Eleven.

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CHAPTER 10
GENERAL INDUSTRY SAFETY AND HEALTH RULES

[Prior to 9/24/86, Labor, Bureau of [530]]
[Prior to 10/7/98, see 347—Ch 10]

875—10.1(88) Definitions. As used in these rules, unless the context clearly requires otherwise:

"Part" means 875—Chapter 10, Iowa Administrative Code.

"Standard" means a standard which requires conditions, or the adoption or use of one or more practices, means, methods, operations, or processes, reasonably necessary or appropriate to provide safe or healthful employment and places of employment.

875—10.2(88) Applicability of standards.

10.2(1) None of the standards in this chapter shall apply to working conditions of employees with respect to which federal agencies other than the United States Department of Labor, exercise statutory authority to prescribe or enforce standards or regulations affecting occupational safety or health.

10.2(2) If a particular standard is specifically applicable to a condition, practice, means, method, operation, or process, it shall prevail over any different general standard which might otherwise be applicable to the same condition, practice, means, method, operation, or process.

10.2(3) However, any standard shall apply according to its terms to any employment and place of employment in any industry, even though particular standards are also prescribed for the industry, as in 1910.12, 1910.261, 1910.262, 1910.263, 1910.264, 1910.265, 1910.266, 1910.267, and 1910.268 of 29 CFR 1910, to the extent that none of such particular standards applies.

10.2(4) In the event a standard protects on its face a class of persons larger than employees, the standard shall be applicable under this part only to employees and their employment and places of employment.

10.2(5) An employer who is in compliance with any standard in this part shall be deemed to be in compliance with the requirement of Iowa Code section 88.4, but only to the extent of the condition, practice, means, method, operation or process covered by the standard.

875—10.3(88) Incorporation by reference. The standards of agencies of the U.S. Government, and organizations which are not agencies of the U.S. Government which are incorporated by reference in this chapter have the same force and effect as other standards in this chapter. Only mandatory provisions (i.e., provisions containing the word "shall" or other mandatory language) of standards incorporated by reference are adopted under the Act.

875—10.4 to **10.6** Reserved.

875—10.7(88) Definitions and requirements for a nationally recognized testing laboratory. The federal regulations adopted at 29 CFR, Chapter XVII, Part 1910, regulation 1910.7 and Appendix A, as published at 53 Fed. Reg. 12120 (April 12, 1988) and amended at 53 Fed. Reg. 16838 (May 11, 1988), 54 Fed. Reg. 24333 (June 7, 1989) and 65 Fed. Reg. 46818 (July 31, 2000) are adopted by reference.

875—10.8 to **10.11** Reserved.

875—10.12(88) Construction work.

10.12(1) *Standards.* The standards prescribed in 875—Chapter 26 are adopted as occupational safety and health standards and shall apply, according to the provisions thereof, to every employment and place of employment of every employee engaged in construction work. Each employer shall protect the employment and places of employment of each employee engaged in construction work by complying with the provisions of 875—Chapter 26.

10.12(2) *Definition.* For the purpose of this rule, *"construction work"* means work for construction, alteration, or repair including painting and redecorating, and where applicable, the erection of new electrical transmission and distribution lines and equipment, and the alteration, conversion, and improvement of the existing transmission and distribution lines and equipment. This incorporation by reference of 875—Chapter 26 (Part 1926) is not intended to include references to interpretative rules having relevance to the application of the construction safety Act, but having no relevance to the application of Iowa Code chapter 88.

875—10.13 to **10.18** Reserved.

875—10.19(88) Special provisions for air contaminants.

10.19(1) *Asbestos, tremolite, anthophyllite, and actinolite dust.* Reserved.

10.19(2) *Vinyl chloride.* Rule 1910.1017 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to vinyl chloride in every employment and place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to vinyl chloride which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

10.19(3) *Acrylonitrile.* Rule 1910.1045 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to acrylonitrile in every employment and place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to acrylonitrile which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

10.19(4) *Inorganic arsenic.* Rule 1910.1018 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to inorganic arsenic in every employment and place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to inorganic arsenic which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

10.19(5) Rescinded, effective 6/10/87.

10.19(6) *Lead.* Rescinded IAB 8/5/92, effective 8/5/92.

10.19(7) *Ethylene oxide.* Rule 1910.1047 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to ethylene oxide in every employment and place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to ethylene oxide which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

10.19(8) *Benzene.* Rule 1910.1028 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to benzene in every place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to benzene which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

10.19(9) *Formaldehyde.* Rule 1910.1048 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to formaldehyde in every place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to formaldehyde which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

10.19(10) *Methylene chloride.* Rule 1910.1052 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to methylene chloride in every employment and place of employment covered by 875—10.12(88) in lieu of any different standard on exposure to methylene chloride which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

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CHAPTERS 11 to 25
Reserved

CHAPTER 26
CONSTRUCTION SAFETY AND HEALTH RULES

[Prior to 9/24/86, Labor, Bureau of [530]]
[Prior to 10/7/98, see 347—Ch 26]

875—26.1(88) Adoption by reference. Federal Safety and Health Regulations for Construction beginning at 29 CFR 1926.16 and continuing through 29 CFR, Chapter XVII, Part 1926, are hereby adopted by reference for implementation of Iowa Code chapter 88. These federal rules shall apply and be interpreted to apply to the Iowa Occupational Safety and Health Act, Iowa Code chapter 88, not the Contract Work Hours and Safety Standards Act, and shall apply and be interpreted to apply to enforcement by the Iowa commissioner of labor, not the United States Secretary of Labor or the Federal Occupational Safety and Health Administration. The amendments to 29 CFR 1926 are adopted as published at:

38 Fed. Reg. 16856 (June 27, 1973)
38 Fed. Reg. 27594 (October 5, 1973)
38 Fed. Reg. 33397 (December 4, 1973)
39 Fed. Reg. 19470 (June 3, 1974)
39 Fed. Reg. 24361 (July 2, 1974)
40 Fed. Reg. 23072 (May 28, 1975)
41 Fed. Reg. 55703 (December 21, 1976)
42 Fed. Reg. 2956 (January 14, 1977)
42 Fed. Reg. 37668 (July 22, 1977)
43 Fed. Reg. 56894 (December 5, 1978)
45 Fed. Reg. 75626 (November 14, 1980)
51 Fed. Reg. 22733 (June 20, 1986)
51 Fed. Reg. 25318 (July 11, 1986)
52 Fed. Reg. 17753 (May 12, 1987)
52 Fed. Reg. 36381 (September 28, 1987)
52 Fed. Reg. 46291 (December 4, 1987)
53 Fed. Reg. 22643 (June 16, 1988)
53 Fed. Reg. 27346 (July 20, 1988)
53 Fed. Reg. 29139 (August 2, 1988)
53 Fed. Reg. 35627 (September 14, 1988)
53 Fed. Reg. 35953 (September 15, 1988)
53 Fed. Reg. 36009 (September 16, 1988)
53 Fed. Reg. 37080 (September 23, 1988)

54 Fed. Reg. 15405 (April 18, 1989)
54 Fed. Reg. 23850 (June 2, 1989)
54 Fed. Reg. 30705 (July 21, 1989)
54 Fed. Reg. 41088 (October 5, 1989)
54 Fed. Reg. 45894 (October 31, 1989)
54 Fed. Reg. 49279 (November 30, 1989)
54 Fed. Reg. 52024 (December 20, 1989)
54 Fed. Reg. 53055 (December 27, 1989)
55 Fed. Reg. 3732 (February 5, 1990)
55 Fed. Reg. 42328 (October 18, 1990)
55 Fed. Reg. 47687 (November 14, 1990)
55 Fed. Reg. 50687 (December 10, 1990)
56 Fed. Reg. 2585 (January 23, 1991)
56 Fed. Reg. 5061 (February 7, 1991)
56 Fed. Reg. 41794 (August 23, 1991)
56 Fed. Reg. 43700 (September 4, 1991)
57 Fed. Reg. 7878 (March 5, 1992)
57 Fed. Reg. 24330 (June 8, 1992)
57 Fed. Reg. 29119 (June 30, 1992)
57 Fed. Reg. 35681 (August 10, 1992)
57 Fed. Reg. 42452 (September 14, 1992)
58 Fed. Reg. 21778 (April 23, 1993)
58 Fed. Reg. 26627 (May 4, 1993)
58 Fed. Reg. 35077 (June 30, 1993)
58 Fed. Reg. 35310 (June 30, 1993)
58 Fed. Reg. 40468 (July 28, 1993)
59 Fed. Reg. 215 (January 3, 1994)
59 Fed. Reg. 6170 (February 9, 1994)
59 Fed. Reg. 36699 (July 19, 1994)
59 Fed. Reg. 40729 (August 9, 1994)
59 Fed. Reg. 41131 (August 10, 1994)
59 Fed. Reg. 43275 (August 22, 1994)
59 Fed. Reg. 65948 (December 22, 1994)

60 Fed. Reg. 9625 (February 21, 1995)
60 Fed. Reg. 11194 (March 1, 1995)
60 Fed. Reg. 33345 (June 28, 1995)
60 Fed. Reg. 34001 (June 29, 1995)
60 Fed. Reg. 36044 (July 13, 1995)
60 Fed. Reg. 39255 (August 2, 1995)
60 Fed. Reg. 50412 (September 29, 1995)
61 Fed. Reg. 5509 (February 13, 1996)
61 Fed. Reg. 9248 (March 7, 1996)
61 Fed. Reg. 31431 (June 20, 1996)
61 Fed. Reg. 41738 (August 12, 1996)
61 Fed. Reg. 43458 (August 23, 1996)
61 Fed. Reg. 46104 (August 30, 1996)
61 Fed. Reg. 56856 (November 4, 1996)
61 Fed. Reg. 59831 (November 25, 1996)
62 Fed. Reg. 1619 (January 10, 1997)
63 Fed. Reg. 1295 (January 8, 1998)
63 Fed. Reg. 1919 (January 13, 1998)
63 Fed. Reg. 3814 (January 27, 1998)
63 Fed. Reg. 13340 (March 19, 1998)
63 Fed. Reg. 17094 (April 8, 1998)
63 Fed. Reg. 20099 (April 23, 1998)
63 Fed. Reg. 33468 (June 18, 1998)
63 Fed. Reg. 35138 (June 29, 1998)
63 Fed. Reg. 66274 (December 1, 1998)
64 Fed. Reg. 22552 (April 27, 1999)
66 Fed. Reg. 5265 (January 18, 2001)
66 Fed. Reg. 37137 (July 17, 2001)

This rule is intended to implement Iowa Code sections 84A.1, 84A.2, 88.2 and 88.5.

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71.5(4) *Prohibited inspections.* A special inspector shall not conduct an inspection of any facility to satisfy the requirements of Iowa Code section 89A.6, if the facility is:

a. Owned or leased by the employer of the inspector, or

b. Under contract for installation, alteration or maintenance by the employer of the special inspector.

71.5(5) *Permitted inspections.* While a special inspector may conduct various types of inspections, the commissioner shall only accept special inspector reports for annual inspections and recheck inspections. The commissioner shall not accept special inspector reports for initial inspections, acceptance inspections or accident investigation reports.

71.5(6) *Reports.* All report forms to be used by special inspectors shall be on forms approved by the commissioner. All reports shall be submitted to the commissioner within 20 days from the date of the special inspection.

875—71.6(89A) Publications available for review. Standards, codes, and publications adopted by reference in these rules are available for review in the office of the Division of Labor Services, 1000 E. Grand Avenue, Des Moines, Iowa.

These rules are intended to implement Iowa Code chapter 89A.

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CHAPTER 155
ASBESTOS REMOVAL AND ENCAPSULATION
[Prior to 10/18/00, see 875—Chs 81 and 82]

875—155.1(88B) Definitions.

"Asbestos" means material containing at least 1 percent by weight of chrysotile, amosite, crocidolite, tremolite asbestos, anthophyllite asbestos, actinolite asbestos or any combination of these minerals. Chemical treatment or alteration does not exempt the material from this definition.

"Asbestos project" means any activity involving the removal or encapsulation of friable asbestos materials, other releases of asbestos such as by the operation of hand-operated or power-operated tools that may produce or release fibers of asbestos, or other substantial alteration of asbestos-containing, nonfriable material. Any activities that do not qualify as construction pursuant to rule 875—150.2(91C) are not asbestos projects.

"Business entity" means a partnership, firm, association, corporation, sole proprietorship, or other business concern. A business entity that uses its own employees in removing or encapsulating asbestos for the purpose of renovating, maintaining or repairing its own facilities is not included.

"Contractor/supervisor" means a person who supervises workers on asbestos projects or a person who enters into contracts to perform asbestos projects and personally completes the work.

"Division" means the division of labor services.

"Friable asbestos material" means any material containing more than 1 percent asbestos by weight and that can be crumbled, pulverized, or reduced to powder by hand pressure when dry.

"Inspector" means a person who inspects for asbestos-containing building materials in a school or a public or commercial building.

"License" means an authorization issued by the division permitting an individual to be employed as a worker, contractor/supervisor, inspector, management planner, or project designer.

"Management planner" means a person who prepares asbestos management plans for a school building.

"Permit" means an authorization issued by the division permitting a business entity to remove or encapsulate asbestos.

"Project designer" means a person who designs asbestos response or maintenance projects for a school or a public or commercial building.

"Worker" means a person who performs response or maintenance activities on one or more asbestos projects.

"Working days" means Monday through Friday including holidays that fall on Monday through Friday. The first working day shall be the date of actual delivery or the postmark date, whichever is earlier. However, documents with Saturday or Sunday postmark dates will be treated as though postmarked on the following Monday.

875—155.2(88B) Permit application procedures.

155.2(1) *Application.* To apply for or to renew a permit, a business entity shall submit a completed application, Form 309-6504, to the division. All requested applicable information and attachments must be provided. A $500 nonrefundable application fee shall accompany each permit application.

155.2(2) *Action on application.* A new permit shall be valid for one year from the date of issuance. A renewal permit shall be valid for one year from the expiration date of the applicant's prior permit. A permit may be denied for the reasons set forth in rule 155.8(17A,88B,252J,261) or if the application package is incomplete. Within 60 days of receiving a completed application package for a new permit, the division will issue a permit or deny the application. Within 30 days of receiving a completed application package for a permit renewal, the division will issue a permit or deny the application. Applications received after expiration of a prior permit will be considered applications for new permits rather than renewals.

875—155.3(88B) Other asbestos regulations. Regulation of encapsulation, removal and abatement procedures are found in 875—Chapters 10 and 26 and 567—Chapter 23. Nothing in this chapter shall be viewed as providing an exemption, waiver, or variance from any otherwise applicable regulation or statute.

875—155.4(88B) Asbestos project records. The permittee shall keep a record of each asbestos project it performs and shall make the record available to the division at any reasonable time. Records required by this rule shall be kept for at least six years. The records shall include:

155.4(1) The name, address, and license number of the individual who supervised the asbestos project and of each employee or agent who worked on the project.

155.4(2) The location and a description of the project and the amount of asbestos material that was removed.

155.4(3) The start and completion dates of each instance of removal or encapsulation.

155.4(4) A summary of the procedures that were used to comply with all applicable standards.

155.4(5) The name and address of each asbestos disposal site where the asbestos-containing waste was deposited.

155.4(6) A receipt from the asbestos disposal site indicating the amount of asbestos and disposal date.

155.4(7) Copies of reports required by 29 CFR 1926.1101(k)(3)(iii).

155.4(8) Copies of air sampling results or initial negative assessment as required by 29 CFR 1926.1101(c).

155.4(9) Material safety data sheets for all solvents used on the asbestos project.

875—155.5(88B) Ten-day notices.

155.5(1) *General.* Permittees shall notify the division at least ten working days before an asbestos project begins. A project begins when site preparations for asbestos abatement, encapsulation, or removal begin; when asbestos abatement, encapsulation, or removal begins; or when any demolition begins, whichever is sooner. Facsimile transmissions of ten-day notices shall not be accepted.

155.5(2) *Emergency.* When there is an immediate danger to life, health or property, the permittee may file the notice within five days after beginning the project. An explanation of the emergency must be included.

155.5(3) *Format.* The notice shall be on an 8½" by 11" sheet of paper and shall contain the following information:

a. The name, address, and telephone number of and contact person for the permittee performing the project.

b. The name, address, and telephone number of the project.

c. A description of the structure and work to be performed, including type and quantity of asbestos-containing material.

d. The anticipated dates of the project's start and end.

e. Designation of the asbestos disposal site.
f. The signature and printed name of the person who completed the form.
g. The shift or work schedule on which the project will be performed.

875—155.6(88B) License application procedures.

155.6(1) *Forms.* Iowa Form 309-2068 must be used for all new and renewal asbestos license applications. The second page of the form is the respirator fit test and the third page is a physician's certification. Forms from other states may not be substituted for the Iowa form or any part thereof. Respirator fit tests and medical examinations must have occurred within the past 12 months. Only worker and contractor/supervisor license applicants must submit the respirator fit test and physician's certification forms. Photocopies of the forms shall not be accepted.

155.6(2) *Training.* A certificate of appropriate training from a course provider approved for asbestos training by the U.S. Environmental Protection Agency must accompany all applications. Applicants for a license must be trained by training providers other than themselves. Applicants who completed initial training under a prior set of applicable rules will not be required to take another initial training course if they complete all annual refresher courses.

155.6(3) *Photographs.* Two 1" by 1" photographs clearly showing the applicant's face shall accompany all license applications.

155.6(4) *Worker licenses.* All persons seeking a license as an asbestos abatement worker shall complete an initial four-day training course and thereafter complete an annual one-day asbestos abatement worker refresher training course. A nonrefundable fee of $20 shall accompany the application.

155.6(5) *Contractor/supervisor licenses.* All persons seeking a license as an asbestos abatement contractor/supervisor shall complete an initial five-day training course and thereafter complete an annual one-day asbestos abatement contractor/supervisor refresher training course. A nonrefundable fee of $50 shall accompany the application.

155.6(6) *Inspector licenses.* All persons seeking a license as an asbestos inspector shall complete an initial three-day training course and thereafter complete an annual one-half-day asbestos inspector refresher training course. A nonrefundable fee of $20 shall accompany the application.

155.6(7) *Management planner licenses.* All persons seeking a license as an asbestos management planner shall complete an initial three-day inspector training course and an initial two-day management planning training course. Thereafter, an annual one-half-day asbestos inspector refresher training course plus an additional one-half-day course on management planning are required. A nonrefundable fee of $20 shall accompany the application.

155.6(8) *Abatement project designer licenses.* All persons seeking a license as an asbestos abatement project designer shall complete an initial three-day abatement project designer training course. Thereafter, an annual one-day asbestos abatement project designer refresher training course is required. A nonrefundable fee of $50 shall accompany the application.

155.6(9) *Action on application.* Within 30 days of receiving a completed application, the division will issue a license or deny the application. If a license is issued, it will expire one year from the date the training was completed. An application may be denied for the reasons set forth in rule 155.8(17A,88B,252J,261) or if the application package is incomplete.

155.6(10) *License on job site.* While conducting asbestos work that requires a license, the license or a legible copy of the license shall be in the licensee's possession at the work site.

875—155.7(88B) Duplicate permits and licenses. Duplicate original permits and licenses are available from the division for a $10 fee.

875—155.8(17A,88B,252J,261) Denial, suspension and revocation.

155.8(1) *Grounds.* The division may deny an application or suspend or revoke a permit or license when an investigation reasonably determines any of the following:

a. Fraud or deception was utilized in obtaining or attempting to obtain a permit or license.

b. The qualifications for a permit or license are not met.

c. Any applicable federal or state standard for removal or encapsulation of asbestos was violated.

d. An unlicensed or untrained person was employed or allowed to work on an asbestos project.

e. The division received a certificate of noncompliance from the college student aid commission or the child support recovery unit of the department of human services.

f. Penalties or other debts are owed by the applicant to the division and are 30 days or more in arrears.

155.8(2) *Relinquishing license or permit.* A licensee or permittee must return the original license or permit to the division when a revocation or suspension becomes final.

155.8(3) *Suspension period.* Unless ordered otherwise, a suspension shall last for 12 months.

875—155.9(17A,88B) Contested cases.

155.9(1) *Scope.* This rule applies to civil penalty assessments and to denials, revocations and suspensions of asbestos licenses and permits.

155.9(2) *Procedures.* The labor commissioner shall serve a notice of intended action by restricted certified mail, return receipt requested, or by other service as permitted by Iowa Code section 17A.8. A notice of contest must be received by the labor commissioner within 20 days after service of the notice of intended action. If a notice of contest is not timely filed, the action stated in the notice of intended action shall automatically be effective. Hearing procedures for asbestos contested cases are set forth in 875—Chapter 1, Division V. However, if a contested case is based on receipt by the division of a certificate of noncompliance, procedures outlined in Iowa Code chapter 252J or 261 shall apply.

These rules are intended to implement Iowa Code chapters 17A, 88B, 252J, and 261.

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CHAPTERS 156 to 159
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Effective date (5/15/85) of 82.3(1)"a"(11) delayed by the Administrative Rules Review Committee until the expiration of forty-five calendar days into the 1986 session of the General Assembly pursuant to Iowa Code section 17A.8(9), IAB 7/31/85.

MINIMUM WAGE

CHAPTER 215
MINIMUM WAGE SCOPE AND COVERAGE

[Prior to 10/21/98, see 347—Ch 215]

875—215.1(91D) Requirement to pay.

215.1(1) Every employer shall pay to each of the employer's employees performing work in this state wages of not less than $5.15 per hour unless otherwise noted in 875—Chapters 215 through 220.

215.1(2) Rescinded IAB 12/12/01, effective 1/16/02.

215.1(3) Rescinded IAB 11/23/94, effective 1/1/95.

875—215.2(91D) Initial employment wage rate.

215.2(1) The wage rate requirement in rule 215.1(91D) does not apply until the employee has completed 90 calendar days of employment with the employer. The 90-day calendar period is counted from the employee's initial day of work. The employer shall pay to each employee who has not completed 90 calendar days of employment at least the following effective wage rates: Effective January 1, 1990, the state minimum initial employment wage rate shall be $3.35 per hour; effective January 1, 1991, the state minimum initial employment wage rate shall be $3.85 per hour; and effective January 1, 1992, the state minimum initial employment wage rate shall be $4.25 per hour.

215.2(2) If the state minimum initial employment wage rate changes during the 90-calendar-day period, the employer shall pay the new effective rate.

215.2(3) If, after less than 90 calendar days from the initial day of work, the employee's employment is terminated and the employee is rehired by the same employer within three years of the initial hiring, the initial employment wage rate in effect at rehiring may be paid until the 90-calendar-day employment period is reached. If, after 90 calendar days from the initial day of work, the employee's employment is terminated and the employee is rehired in less than three years from the last date of employment, the employee shall not be employed at the initial employment wage rate. The rates specified in 215.1(2) shall apply as the minimum wage rate.

215.2(4) In the event the federal minimum wage is greater than the rates established in 215.2(1), the employer is not required by these rules to pay the higher rate. The employer may be required to pay the higher rate under federal law.

875—215.3(91D) Definitions. As used in 875—Chapters 216 to 220:

215.3(1) *"Agriculture"* includes farming in all its branches and among other things includes the cultivation and tillage of the soil; dairying; the production, cultivation, growing, and harvesting of any agricultural or horticultural commodities (including commodities defined as agricultural commodities in Section 15(g) of the Agricultural Marketing Act, as amended); the raising of livestock, bees, furbearing animals, or poultry; and any practices (including any forestry or lumbering operations) performed by a farmer or on a farm incident to or in conjunction with farming operations, including preparation for market, delivery to storage or to market or to carriers for transportation to market.

215.3(2) *"American vessel"* includes any vessel which is documented or numbered under the laws of the United States.

215.3(3) *"Commissioner"* means the labor commissioner or the commissioner's designee.

215.3(4) *"Commerce"* means trade, commerce, transportation, transmission, or communication among the several states or between any state and any place outside thereof.

215.3(5) *"Elementary school"* means a day or residential school which provides elementary education, as determined under state law.

215.3(6) *"Employ"* includes to suffer or permit to work.

215.3(7) *"Employee"* means any individual employed by an employer. In the case of an individual employed by a public agency, the term means any individual employed by the state, political subdivision of the state, or an interstate governmental agency, other than the individual:

a. Who is not subject to the civil service laws of the state, political subdivision, or agency which employs the individual; and

b. Who

(1) Holds a public elective office of that state, political subdivision, or agency,

(2) Is selected by the holder of the office to be a member of the holder's personal staff,

(3) Is appointed by the officeholder to serve on a policy-making level,

(4) Is an immediate adviser to the officeholder with respect to the constitutional or legal powers of the office, or

(5) Is an employee in the legislative branch or legislative body of that state, political subdivision, or agency and is not employed by the legislative library of the state, political subdivision, or agency.

215.3(8) *"Employee"* does not mean:

a. For purposes of the definition of "Person-day," any individual employed by an employer engaged in agriculture if the individual is the parent, spouse, child, or other member of the employer's immediate family.

b. Any individual who volunteers to perform services for a public agency which is the state, a political subdivision of the state, or an interstate government agency, if:

(1) The individual receives no compensation or is paid expenses, reasonable benefits, or a nominal fee to perform the services for which the individual volunteered; and

(2) The services are not the same type of services which the individual is employed to perform for the public agency.

However, an employee of a public agency which is the state, political subdivision of the state, or an interstate governmental agency may volunteer to perform services for any other state, political subdivision, or interstate governmental agency, including a state, political subdivision or agency with which the employing state, political subdivision, or agency has a mutual aid agreement.

215.3(9) *"Employer"* includes any person acting directly or indirectly in the interest of an employer in relation to an employee and includes a public agency, but does not include any labor organization (other than when acting as an employer) or anyone acting in the capacity of officer or agent of the labor organization.

215.3(10) *"Enterprise"* means the related activities performed (either through unified operation or common control) by any person or persons for a common business purpose, and includes all activities whether performed in one or more establishments or by one or more corporate or other organizational units including departments of an establishment operated through leasing arrangements. Enterprise shall not include the related activities performed for the enterprise by an independent contractor, provided that, within the meaning of this definition, a retail or service establishment which is under independent ownership shall not be deemed to be so operated or controlled as to be other than a separate and distinct enterprise by reason of any arrangement, which includes, but is not necessarily limited to, an agreement:

a. That it will sell, or sell only, certain goods specified by a particular manufacturer, distributor, or advertiser;

b. That it will join with other establishments in the same industry for the purpose of collective purchasing; or

875—215.4(91D) Exceptions. The rules contained in 875—Chapters 215 to 220 shall not apply with respect to:

215.4(1) Any employee employed in a bona fide executive, administrative, or professional capacity (including any employee employed in the capacity of academic administrative personnel or teacher in elementary or secondary schools), or in the capacity of outside salesperson (except that an employee of a retail or service establishment shall not be excluded from the definition of employee employed in a bona fide executive or administrative capacity because of the number of hours in employee's workweek which the employee devotes to activities not directly or closely related to the performance of executive or administrative activities, if less than 40 percent of the employee's hours worked in the workweek are devoted to the activities).

215.4(2) Any employee employed by a retail or service establishment (except an establishment or employee engaged in laundering, cleaning, or repairing clothing or fabrics or an establishment engaged in the operation of a hospital, institution, or school described and defined in 215.3(11)*"e"*) if more than 50 percent of the establishment's annual dollar volume of sales of goods or services is made within the state in which the establishment is located, and the establishment is not in an enterprise described and defined in 215.3(11). A "retail or service establishment" shall mean an establishment 75 percent of whose annual dollar volume of sales of goods or services (or of both) is not for resale and is recognized as retail sales or services in the particular industry.

215.4(3) Any employee employed by an establishment which is an amusement or recreational establishment, organized camp, or religious or nonprofit education conference center, if

a. It does not operate for more than seven months in any calendar year, or

b. During the preceding calendar year, its average receipts for any six months of such year were not more than 33 1/3 percent of its average receipts for the other six months of the year, except that the exemption provided does not apply with respect to any employee of a private entity engaged in providing services or facilities (other than a private entity engaged in providing services and facilities directly related to skiing) in a national park or a national forest or on land in the National Wildlife Refuge System, under a contract with the Secretary of the Interior or the Secretary of Agriculture.

215.4(4) Any employee employed by an establishment which qualifies as an exempt retail establishment under 215.4(2) and is recognized as a retail establishment in the particular industry notwithstanding that the establishment makes or processes at the retail establishment the goods that it sells, provided that more than 85 percent of the establishment's annual dollar volume of sales of goods so made or processed is made within the state in which the establishment is located.

215.4(5) Any employee employed in the catching, taking, propagating, harvesting, cultivating, or farming of any kind of fish, shellfish, crustacean, sponges, seaweeds, or other aquatic forms of animal and vegetable life, or the first processing, canning or packing such marine products at sea as an incident to, or in conjunction with, such fishing operations, including the going to and returning from work and loading and unloading when performed by any employee.

215.4(6) Any employee employed in agriculture:

a. If the employee is employed by an employer who did not, during any calendar quarter during the preceding calendar year, use more than 500 person-days of agricultural labor;

b. If the employee is the parent, spouse, child, or other member of the employer's immediate family;

c. If the employee:

1. Is employed as a hand harvest laborer and is paid on a piece-rate basis in an operation which has been, and is customarily and generally recognized as having been, paid on a piece-rate basis in the region of employment,

2. Commutes daily from the employee's permanent residence to the farm on which the employee is employed, and

3. Has been employed in agriculture less than 13 weeks during the preceding calendar year;

d. If the employee (other than an employee described in 215.4(6)"*c*"):

1. Is 16 years of age or under and is employed as a hand harvest laborer, is paid on a piece-rate basis in an operation which has been, and is customarily and generally recognized as having been, paid on a piece-rate basis in the region of employment,

2. Is employed on the same farm as the employee's parent or person standing in the place of the employee's parent, and

3. Is paid at the same piece rate as employees over age 16 are paid on the same farm; or

e. If the employee is principally engaged in the range production of livestock.

215.4(7) Any employee to the extent that the employee is exempted by regulations, order, or certificate of the Secretary of Labor issued under the federal Fair Labor Standards Act, 29 U.S.C. 214.

215.4(8) Any employee employed in connection with the publication of any weekly, semiweekly, or daily newspaper with a circulation of less than 4,000, having the major part of its circulation within the county where published or counties contiguous thereto.

215.4(9) Reserved.

215.4(10) Any switchboard operator employed by an independently owned public telephone company which has not more than 750 stations.

215.4(11) Reserved.

215.4(12) Any employee employed as a stevedore on a vessel other than an American vessel.

215.4(13) Reserved.

215.4(14) Any employee employed on a casual basis in domestic service employment to provide babysitting services or any employee employed in domestic service employment to provide companionship services for individuals who (because of age or infirmity) are unable to care for themselves.

215.4(15) Any enterprise whose annual gross volume of sales made or business done (exclusive of excise taxes at the retail level which are separately stated) falls below the applicable amount so stated in 215.3(11) which initially required compliance. Future compliance shall be determined following each succeeding quarter with the gross volume of sales made or business done (exclusive of excise taxes at the retail level which are separately stated) from the most recent four quarters being totaled to determine an annual gross. The gross amount initially requiring compliance shall continue in effect.

SOURCE: 29 U.S.C. 213.

875—215.5(91D) Interpretative guidelines. The rules contained in 875—Chapters 215 to 220 are based on the federal rules indicated at the end of each rule. The federal rules contained illustrative examples of the application of the rule. The examples are not adopted, but the commissioner will be guided in enforcement by the examples provided in the rules. The Secretary of Labor has adopted statements of general policy and interpretations not directly related to regulations at 29 CFR Parts 776, 779, 780, and 785. The commissioner will follow these statements and interpretations in the application and enforcement of Iowa Code chapter 91D.

These rules are intended to implement Iowa Code chapter 91D.

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